



**Maternal and Child Health Services  
Title V Block Grant**

**State Narrative for  
Indiana**

**Application for 2015  
Annual Report for 2013**



Document Generation Date: Tuesday, July 15, 2014

# Table of Contents

I. General Requirements .....	4
A. Letter of Transmittal.....	4
B. Face Sheet .....	4
C. Assurances and Certifications.....	4
D. Table of Contents .....	4
E. Public Input.....	4
II. Needs Assessment.....	7
C. Needs Assessment Summary .....	7
III. State Overview .....	9
A. Overview.....	9
B. Agency Capacity.....	19
C. Organizational Structure.....	30
D. Other MCH Capacity .....	34
E. State Agency Coordination.....	38
F. Health Systems Capacity Indicators.....	44
Health Systems Capacity Indicator 05B:.....	44
IV. Priorities, Performance and Program Activities .....	46
A. Background and Overview .....	46
B. State Priorities .....	47
C. National Performance Measures.....	50
Performance Measure 01:.....	50
Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated .....	54
Performance Measure 02:.....	54
Performance Measure 03:.....	58
Performance Measure 04:.....	62
Performance Measure 05:.....	66
Performance Measure 06:.....	70
Performance Measure 07:.....	74
Performance Measure 08:.....	77
Performance Measure 09:.....	80
Performance Measure 10:.....	83
Performance Measure 11:.....	87
Performance Measure 12:.....	89
Performance Measure 13:.....	92
Performance Measure 14:.....	95
Performance Measure 15:.....	98
Performance Measure 16:.....	101
Performance Measure 17:.....	103
Performance Measure 18:.....	106
D. State Performance Measures.....	109
State Performance Measure 1: .....	109
State Performance Measure 2: .....	111
State Performance Measure 3: .....	114
State Performance Measure 4: .....	117
State Performance Measure 5: .....	119
State Performance Measure 6: .....	122
State Performance Measure 7: .....	125
State Performance Measure 8: .....	128
State Performance Measure 9: .....	130
State Performance Measure 10: .....	133
E. Health Status Indicators .....	136
Health Status Indicators 01A:.....	136

F. Other Program Activities .....	137
G. Technical Assistance .....	139
V. Budget Narrative .....	141
Form 3, State MCH Funding Profile .....	141
Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds.....	141
Form 5, State Title V Program Budget and Expenditures by Types of Services (II) .....	142
A. Expenditures.....	142
B. Budget .....	143
VI. Reporting Forms-General Information .....	144
VII. Performance and Outcome Measure Detail Sheets .....	144
VIII. Glossary .....	144
IX. Technical Note .....	144
X. Appendices and State Supporting documents.....	144
A. Needs Assessment.....	144
B. All Reporting Forms.....	144
C. Organizational Charts and All Other State Supporting Documents .....	144
D. Annual Report Data .....	144

## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.

***An attachment is included in this section. IA - Letter of Transmittal***

### **B. Face Sheet**

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

### **C. Assurances and Certifications**

Assurances and Certifications are kept on file at the Indiana State Department of Health in the Office of Grants Management. They are available upon request.

### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

### **E. Public Input**

The State Title V program solicited public comments for this application using several methods. The first method was to place a request for public comments on the Maternal and Child Health (MCH) web page for ongoing public input. The web page encourages the public to comment on the previous, and the current years Title V Block Grant. This includes the Narrative, Forms, and a 2010 Executive Summary which is updated yearly.

A second method for soliciting public comments involved the use of surveys for identifying priority needs for the Five Year Needs Assessment from providers, partners, collaborators, disparity families and families of children with special healthcare needs. The surveys were either used for collecting comments of individuals in group settings, mailed by request to individuals, or electronically e-mailed to professionals. Professionals who were surveyed in small group settings included but were not limited to: Prenatal Substance Abuse (PSUPP) statewide directors, the Indiana Coalition to Improve Adolescent Health (ICIAH) steering committee, the Healthy Families of Indiana Think Tank, Indiana State Department of Health's Chronic Disease Division, State Perinatal Advisory Board, Indiana State Nutrition Council, an Indiana University-Purdue University-Indianapolis nursing class, a Butler University health class, Sunny Start core partners group, Sunny Start Family Advisory Subcommittee, Sunny Start Evaluation Subcommittee, WIC Breastfeeding Committee, the Breast Feeding Center at Clarian, WIC Steering Committee, Indiana Dietitian Associations Meeting, Indiana Nutrition Council, Infant Health & Survival Council, and Indiana's FIMRs.

Needs assessment surveys were sent by e-mail to the 139 member Virtual Advisory Committee, 92 Local Health Departments (LHD) and listed on the LHD Sharepoint, all community health centers, and to all MCH clinics. Surveys were mailed to any professional upon their request. A copy of the Completed Title V Block Grant will be e-mailed to the states public library system for access in their government document sections.

In surveying these small groups and individuals MCH was able to obtain input from a cross section of disciplines. It included but was not limited to the following professions: health service directors, physicians, registered nurses, public health professionals, students, educators, social workers, lactation specialists, Healthy Family Workers, clinic staff, early childhood service providers, outreach workers, WIC staff, registered dietitians, and fundraisers. These individuals reside in over two-thirds of Indiana's 92 counties, but their service delivery systems represent all of Indiana.

A third method for soliciting public comments before the submission of the Title V Block Grant involved the use of a twenty-page MCH Title V Block Grant Executive Summary. The summary was sent out the first week of June 2010 to the expanded 250 Virtual Advisory Committee members, all LHDs, MCH clinics, 131 Indiana libraries, community health centers, MCH Network/Community Partners, and the Minority Health Coalitions. All groups were advised that the Title V Five Year Needs Assessment and Grant Application had to be submitted no later than July 15, 2010. Therefore their deadline for submitting comments could be no later than Friday, June 25th. As of July 6, over 15 reviewers submitted comments. Title V staff have reviewed All comments and have incorporated as many comments as possible into the needs assessment. All public comments received after submission of the current Title V Block Grant will be used during the preparation of the application for the following year.

Loren Robertson, Deputy Commissioner at Indiana State Department of Health (ISDH) commented that smoking during pregnancy is an extremely important issue. A sampling of other public comments include:

"I have read and agree with the goals outlined to meet the state's priority health issues and needs. I found the ten goals that have been identified as needed areas for improvement in Indiana to be appropriate and necessary. I believe the work plan outlined with each of these goals will allow Indiana to attain the projected outcomes."

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"The goal over the next five years is to reduce the proportion of births that occur within 18 months of a previous birth, to the same mother, to the level of 10% from (INCLUDE CURRENT LEVEL) I WOULD SUGGEST WORKING WITH FATHERHOOD INITIATIVE ON THIS ONE TOO! THEY NEED EDUCATION ABOUT THIS ISSUE MORE THAN MOMS!"

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"As the CEO of Learning Well school-based clinics in Marion County, I would like to offer the mention of our relationship with the State in order to add the power of our large, 9 year collaboration with healthcare providers; school partners; and advisory partners (including local foundations, the United Way of Central Indiana, Health & Hospital Corporation, Clarian....and many others) to an already strong proposal. I have attached a list of the working partnerships and collaborations that are presently in place. I noted there are many areas where Learning Well could be utilized as a prime example of how the State of Indiana has been successful in creating programs that are based upon partnerships and collaborations."

Donna A. Stephens, MBA

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/2012/Title V staff continue to reach out to providers, parents, families, partners, and collaborators for continued input into Title V programs and policies. As an example of the importance of public input, Title V staff have strengthened statewide partnerships with specialty physicians, hospitals, and other relevant entities and created a Perinatal Quality Improvement Collaborative. Also this year, we are working on an interactive web-based presentation of the Title V Five Year Needs Assessment. We also encourage collaboration by making it a requirement of grant sub-awards. Subsequent to the Title V Five Year Needs Assessment, we have conducted two additional needs assessments -- one focused on home visiting and the other focused on pregnant and parenting teens. In both instances, we sought public input through surveys and meetings to make our needs assessments the strongest they could be. We are continuing to seek out public input, especially from pregnant and parenting teens and their families. To this end, IU is convening a three-day community conversation with pregnant and parenting teens and the community that is scheduled for summer 2011. The conversation will be facilitated by research sociologists from Indiana University. "Families served by MCH and CSHCS programs routinely encounter opportunities both informal and formal to share their input. These opportunities via surveys, public forums and advisory work are a key piece of the family partnership that enhances MCH and CSHCS." -- Rylin Rodgers, Family Voices Indiana//2012//

/2013/ MCH has continued in its efforts to work with community and public partners. As an example, Sunny Start recently completed a statewide Community Survey. The distribution of the survey resulted in 508 individual responses from 152 families and 356 community providers. Forty-eight of the 92 counties in Indiana were represented. As an example, one respondent said, in response to an open-ended question about actions needed to ensure services are coordinated, cost effective and community based, that "We really need a one-stop shopping - one place families can go to get information and access resources." The information from this survey will guide Sunny Start's activities in the next few years.//2013//

## **II. Needs Assessment**

In application year 2015, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

### **C. Needs Assessment Summary**

#### ***/2015/ Population Strengths and Needs***

*Indiana's infant mortality rate decreased from 7.7 to 6.7 between 2011 and 2012. However, the 2012 infant mortality rate of 6.7 is an underestimate of the infant mortality problem in Indiana. It is possible that some deaths may not have been included in reporting for 2012 due to vital records not receiving all the death certificates. The 2012 IMR is considered an outlier in Indiana with the past trend analysis and the 2013 IMR already trending higher than 6.7 per 1,000 live births. While the overall infant mortality rate improved, a significant disparity continues to exist between black and white infant mortality. This disparity grew larger between 2011 and 2012, with black infant mortality rates increasing and white infant mortality rates decreasing. Black infant mortality in 2011 was 12.3 and increased to 14.5 in 2012. White infant mortality was 6.9 in 2011 and dropped to 5.5 in 2012. There was a decrease in the percentage of Indiana preterm births, from 10.0% in 2011 to 9.6% in 2012. The percentage of babies born at a low birth weight and very low birth weight also decreased between 2011 and 2012 (8.1% to 7.9%, 1.5% to 1.3% respectively).*

*The percentage of mothers having a birth occurring within 18 months of a previous birth was 33.2% in 2012, compared to 33.5% in 2011. As mentioned in FY 2011 and 2012 Needs Assessments, utilizing the data from the 2003 version of the birth certificate has had an effect on the percent of mothers receiving prenatal care. Between 2011 and 2012, the percentage of Indiana pregnant women receiving prenatal care in the first trimester increased slightly from 68.1% to 68.4%. The percentage of women ages 15-44 receiving at least adequate prenatal care according to the Kotelchuck index in 2012 was 73.1%, up from 72.1% in 2011. The percentage of black women ages 15-44 receiving at least adequate prenatal care according to the Kotelchuck Index was 60.1%% in 2012, an increase from 57.7% in 2011.*

#### ***Changes in MCH Programs Capacity***

*The Epidemiology Surveillance and Data Analysis Division is under the direction of Joseph Haddix. Since the last Needs Assessment, Eileen White left the MCH Epidemiology team and Stephanie Moles transitioned to a Data Analyst for the MCH Division. The team added a new epidemiologist in 2014, Kendra Ham. The MCH Epidemiology team is currently comprised of Kelsey Gurganus, Tiffany Davis and Kendra Ham.*

#### ***Ongoing Activities and Needs***

*The top priority of the Indiana State Department of Health is an infant mortality initiative. The epidemiology division is working in concert with the Indiana Perinatal Quality Improvement Collaborative (IPQIC), involving hospitals and concerned entities such as March of Dimes, to institute new standards of care for both obstetric and neonatal units throughout the state. This effort will focus on decreasing complications resulting in morbidity and mortality for mothers and infants in Indiana. Levels of care for hospitals will be assigned according to established criteria, in an effort to give risk-appropriate care for every pregnant woman in the state. We are currently in the process of hiring nurses with NICU/OB experience in order to act as hospital surveyors and implement the 2012 Indiana Perinatal Hospital Standards. We are also hiring a public relations firm to provide state-wide education through billboards, public service announcements, print media, online/social media, radio and television, and community forums. Their contract runs through December 2015. We hired an Infant Mortality Education Liaison to assist in the*

*state-wide education efforts of our public relations firm, but also to provide more community-based education and technical assistance regarding specific infant mortality issues that certain communities are facing. Lastly, since summer of 2013, ISDH has worked collaboratively with Department of Child Services' Permanency Program regarding safe sleep. Through this on-going collaboration, we have decided to eliminate the out-sourcing of the safe sleep program and ISDH will be hiring a Safe Sleep Coordinator by July 1, 2014 to work between both agencies to provide statewide education on safe sleep in accordance with the ISDH infant mortality plan and to provide oversight of the Cribs for Kids program for DCS. //2015//.*



### III. State Overview

#### A. Overview

Indiana is a state rich with the history of an industrial and agricultural past and the promise of an agricultural and high tech future. Like the rest of the country, this past year has forced the State to deal with serious changes and hardships due to the United States' economic downturn. However, Indiana has fared far better than most of its neighbors and most of the country. Under Governor Mitch Daniels' administration, innovative programs have emerged to combat high unemployment and the lack of health insurance that accompanies such changes.

#### State Introduction

The Indiana State Department of Health (ISDH), one of the largest state agencies, serves the population in a wide variety of ways including providing environmental public health, food protection services, health facility licensing, public health preparedness, health promotion programs, statistical information, direct health services, and many other infrastructure building programs.

The Mission of the ISDH supports Indiana's economic prosperity and quality of life by promoting, protecting and providing for the health of Hoosiers in their communities. To achieve this mission, ISDH has adopted principles that guide policy development and programs. These principles mandate that ISDH and its Commissions:

- Focus on data-driven policy to determine appropriate evidence-based programs and initiatives.
- Evaluate activities to ensure measurable results.
- Engage partners and include appropriate intra-agency programs in policy-making and programming.
- View essential partners to include local health departments, physicians, hospitals and other health care providers, other state agencies and officials as well as local and federal agencies and officials, community leaders, businesses, health insurance companies, Medicaid, health and economic interest groups, and other groups outside the traditional public health model.
- Actively facilitate the integration of public health and health care activities to improve Hoosiers' health.

//2013/ ISDH adopted a new Mission, Vision, and Strategic Priorities in 2012. They are as follows.

#### Mission:

"Promoting and providing essential public health services to protect Indiana communities"

#### Vision:

A healthier and safer Indiana

#### Agency Strategic Priorities:

The Indiana State Department of Health believes that the following agency priorities will have the most impact on the way it operates and on its ability to deliver on its Mission and Vision:

- Decrease disease incidence and burden
- Improve response and preparedness networks and capabilities
- Reduce administrative costs through improving operational efficiencies
- Recruitment, evaluation, and retention of top talent in public health
- Better use of information and data from electronic sources to develop and sponsor outcomes-driven programs
- Improve relationships and partnerships with key stakeholders, coalitions and networks throughout the State of Indiana//2013// /2014/ Reducing infant mortality has become the number one priority of the agency. Other priorities include improving child immunization rates, decreasing obesity, and decreasing smoking. //2014// **/2015/ Reducing infant mortality, adult obesity, and adult smoking remain the top three priorities for the agency. //2015//**

In its desire to make Indiana the healthiest state in the country, ISDH also recognizes that key

factors such as prevention of disease, ensuring access to health care, and promoting personal responsibility of individual Hoosiers for their own health must also be an integral part of the state's initiatives. ISDH works hard to collaborate effectively with its many partners in policy-making and programming. ISDH also works hard to develop an environment of respect -- for those who serve Hoosiers in the public health field and the public it serves -- by honoring diversity, equality of opportunity, cultural differences, and ethical behavior.

As of January 2010, the State's Priority Health Initiatives included activities that support data driven efforts for both health conditions and health system initiatives; INShape Indiana; and integration of medical policy that values public health principles; and preparedness. The state is emphasizing the integration of health care policies with evidence-based and results oriented programming. It also continues to highlight preparedness and effective responses to threats that cannot be prevented.

In particular, InShape Indiana is a statewide initiative designed to help Hoosiers make healthier choices about food, physical activity and tobacco. Governor Daniels began this program and remains heavily involved in support of this program. The website link (<http://www.in.gov/inshape/>) provides access to valuable information and resources that can help Hoosiers live a more healthful life. As a result of the initiative, thousands of Hoosiers have decided to start living a healthier lifestyle by choosing to eat better, move more and avoid tobacco.

#### Health Status and Health Needs of Hoosiers

In comparison to other states, the health status of Hoosiers is below average. However, Indiana does have certain strengths including a low rate of uninsured population at 11.9%, increasing immunization coverage of children, and decreasing cardiovascular deaths. In the past ten years, immunization coverage increased from 41.8% to 78.4% of children ages 19 to 35 months who received complete immunizations. Since 1990, the rate of deaths from cardiovascular disease decreased from 425.0 to 310.0 deaths per 100,000 population.

In terms of state challenges, Indiana ranks poorly on the prevalence of smoking at 26.0% (the same rate as in 1999); high levels of pollution at 13.2 micrograms of fine particulate per cubic meter; 49th in public health funding at \$36 per person; and a high percentage (23.3%) of children in poverty. In the past five years, the percentage of children in poverty increased from 13.7 % to 23.3 % of persons under age 18. Additionally, Indiana ranks 37th in cardiovascular deaths; 37th in cancer deaths; and 39th in overall infant mortality. Compared to 43 other states that have sufficient data, Indiana ranks 40th in terms of black infant mortality. (Infant mortality rates by state 2004-2006, [Statehealthfacts.org](http://Statehealthfacts.org/))/2012/The percentage of adults smoking decreased to 23.1% in 2009 according to the BRFSS.//2012// /2013/ Most recently, the Indiana Smoke Free Air Law began on July 1, 2012, which will make nearly all public places, including restaurants and workplaces, smoke free.//2013//

Health disparities are also a very large issue in Indiana. Obesity is more prevalent among non-Hispanic blacks than non-Hispanic whites at 36.7% vs. 27.2 % respectively. The prevalence of diabetes also varies by race and ethnicity in the state; 12.9 % of non-Hispanic blacks have diabetes compared to 7.7 % of Hispanics and 8.4 % of non-Hispanic whites.

In 2007, the total infant mortality rate in Indiana was 7.5 per 1,000. The white non-Hispanic rate was 6.5 per 1,000, the black non-Hispanic rate was 15.7 per 1,000 and the Hispanic rate was 6.8 per 1,000. The low birth weight for infants in Indiana in 2007 was 8.5 % of births. The percentages were 7.8% for white non-Hispanic, 14.1% for black non-Hispanic and 7.2% for Hispanic for low birth weight infants in Indiana in 2008. /2013/In 2009, the infant mortality rate increased to 7.8 while the percent of low birth weight infants decreased to 8.3%.//2013// /2014/ In 2011 (provisional), the infant mortality rate decreased to 7.7 while the percent of low birth weight infants decreased to 8.1% //2014// **/2015/ In 2012 (provisional), the infant mortality rate decreased to 6.7 while the percent of low birth weight infants decreased to 7.9%. //2015//**

## Demographics

The State of Indiana is located in the Great Lakes Region of the United States. Indiana is ranked 38th in land area, and is the smallest state in the continental U.S. west of the Appalachian Mountains. Its capital and largest city is Indianapolis, the largest of any state capital east of the Mississippi River. As of 2008, Indiana is the 38th most populated state in the United States with 6,376,792 people living in 2,795,024 households. Indiana has several metropolitan areas with populations greater than 100,000 as well as a number of smaller industrial cities and small towns. Residents of Indiana are known as Hoosiers./2012/Based on the 2010 census, Indiana's population is now 6,483,802. Since 2000, Indiana's population has increased by 6.6% which is below the national average of 9.7%./2012//

Indianapolis ranks as the 13th largest city and 11th largest metropolitan area in the United States, and also the 3rd largest city in the Midwest. The Indianapolis Metropolitan Area, defined as Marion County and the counties immediately surrounding it, is among the fastest-growing metropolitan areas in the US, with the largest growth centering in the counties surrounding Marion County. (FY2008, US Census Bureau.)

In the state, 26.9% of the population are under the age of 18, 6.9% are under the age of five and 12.8% are 65 years of age or older. The median age is 36.4 years. In 2005, 77.7% of Indiana residents lived in metropolitan counties. In Indiana, the population is 51% female and 49% male.

Indiana has limited cultural diversity outside of its metropolitan areas with over two-thirds of its counties reporting white, non-Hispanic populations of more than 95%. Indiana's overall Hispanic population is 5.2%, its white, non-Hispanic population is 83.2%, and its black non-Hispanic population just over 9%. This contrasts highly with Indiana's largest county, Marion County, which has an African-American population of 25.9%, a Hispanic population of 7.4%, and a white, non-Hispanic population of 63.8%. Asians and people reporting two or more races account for almost all of the remaining 2.9%.

Indiana's economy is considered to be one of the most business-friendly in the United States. This is due in part to its conservative business climate, low business taxes, relatively low union membership, and labor laws. The doctrine of at will employment, whereby an employer can terminate an employee for any or no reason, is in force.

Despite its reliance on manufacturing, Indiana has been much less affected by declines in traditional rust belt manufactures than many of its neighbors. According to the Bureau of Labor Statistics, Indiana is one of very few states where the unemployment rate declined from March 2009 to March 2010 (10.1 vs. 9.9%). The explanation appears to be certain factors in the labor market. First, much of the heavy manufacturing, such as industrial machinery and steel, requires highly skilled labor, and firms are often willing to locate where hard-to-train skills already exist. Second, Indiana's labor force is located primarily in medium-sized and smaller cities rather than in very large and expensive metropolises. This makes it possible for firms to offer somewhat lower wages for these skills than would normally be paid. Firms often see in Indiana a chance to obtain higher than average skills at lower than average wages.

Indiana is home to the international headquarters of pharmaceutical company Eli Lilly in Indianapolis, the state's largest corporation, as well as the world headquarters of Mead Johnson Nutritionals in Evansville. Overall, Indiana ranks fifth among all the states in total sales and shipments of pharmaceutical products and second highest in the number of biopharmaceutical related jobs.

Indiana is located within the U.S. corn and grain belts. The state has a feedlot-style system raising corn to fatten hogs and cattle. Along with corn, soybeans are also a major cash crop. Indiana's proximity to large urban centers, like Chicago and Indianapolis, supports dairying, egg production, and specialty horticulture. Other crops include melons, tomatoes, grapes, mint, popping corn, and tobacco in the southern counties.

## Poverty

For all age groups, Indiana has less people living in poverty than the nation as a whole. However, Indiana has slightly more children than the nation as a whole who live in households lower than 100% of the Federal Poverty Level. Additionally, Indiana's median income, \$50,303 is below the national average. ([www.statehealthfacts.org](http://www.statehealthfacts.org))

In terms of poverty rate by race/ethnicity, Indiana's black population is significantly more affected by poverty than the rest of the black population in the United States. The black population living in Indiana is almost three times more likely to suffer from poverty. According to a 2007 GAO report titled, *POVERTY IN AMERICA: Economic Research Shows Adverse Impacts on Health Status and Other Social Conditions As Well As the Economic Growth Rate*, economic research suggests that individuals living in poverty face an increased risk of adverse outcomes, such as poor health and criminal activity, both of which may lead to reduced participation in the labor market. While the mechanisms by which poverty affects health are complex, some research suggests that adverse health outcomes can be due, in part, to limited access to health care as well as greater exposure to environmental hazards and engaging in risky behaviors.

Additionally, exposure to higher levels of air pollution from living in urban areas close to highways can lead to acute health conditions. Data suggest that engaging in risky behaviors, such as tobacco and alcohol use, a sedentary life-style, and a low consumption of nutritional foods, can account for some health disparities between lower and upper income groups.

The relationship between poverty and adverse outcomes for individuals is complex, in part because most variables, like health status, can be both a cause and a result of poverty. These adverse outcomes affect individuals in many ways, including limiting the development of skills, abilities, knowledge, and habits necessary to fully participate in the labor force.

Low-income children are less likely to be covered by healthcare and thus are more likely to lack primary care and other necessary medical services. Because of these disparities, providing services to children from low-income households is of paramount concern for our nation and has led to national coverage programs for children. Healthcare financing sources for low-income and disabled children include Medicaid and SCHIP funding, administered in Indiana through Hoosier Healthwise which includes a risk-based managed care (RBMC) program, Care Select for aged, blind, disabled, and other special populations, and fee-for service Medicaid programs.

According to information compiled by Covering Kids and Families (CKF) in Indiana, there are 1,680,000 children under the age of 19 in Indiana. Of these children, about one in 10 (or 161,000) has no health insurance. /2013/The number of uninsured children in Indiana has decreased to 9.1% (or 148,000) in 2009./2013//

- Indiana ranked 35th in the nation in 2006 for the number of children living in poverty.
- 95.3% of Indiana's uninsured children are members of working families. (Families USA)
- In 2007, 7% of Indiana's children under the age of 6 were uninsured.
- In 2007, 8% of Indiana's children between the ages of 6 and 12 were uninsured; 14% of children between the ages of 13 and 18 were uninsured.
- 48.2% of Indiana's uninsured children live in families with annual incomes at or below twice the federal poverty level (Families USA 2008)
- Indiana had the highest per capita rate of individual medical bankruptcies in the nation in 2006.
- From 1999 to 2005, Indiana had the nation's highest percentage drop in workers who receive employer-sponsored health insurance.

At the Governor's direction, Indiana is working diligently to improve the economic status of Hoosier children and their families.

## Racial/Ethnic Disparity

Like the rest of the United States, Indiana is growing more diverse culturally, racially, and ethnically. This change will continue to increase over the coming years and will enrich Indiana as

a state and help to expand its global perspective. However, while there are many positive outcomes due to this growth, there are also problems, such as inadequate health delivery.

The National Institutes of Health states that "Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the US." It is racial and ethnic minorities that are facing a disproportionately greater burden of disease, injury, premature death, and disability. Indiana's MCH and CSHCS programs are aware of racial and ethnic health disparities in Indiana and are working to impact the many contributing factors that influence an individual's health. These factors include but are not limited to the environment, lifestyle choices, cultural beliefs, poverty, past experiences, insurance status, and employment. Additionally, racial and ethnic minorities also experience barriers to health including access to care; limited English proficiency; no continual source of health care; limited health education; racial and ethnic assumptions; and lack of diverse employment skills.

Reducing health disparities among racial and ethnic groups in Indiana requires the cooperation of legislators, governments (both local and state), providers of health care, and the community. Improved data collection, better access to care, essential preventative care, and community involvement are also necessary to improve current health status and conditions of all racial and ethnic minority groups.

Minority, racial, and ethnic populations in Indiana make up more than 15% of the current population. Overall, blacks have the highest age-adjusted death rates, followed by whites and Hispanics.

In Indiana, the black non-Hispanic population consistently has more severe health outcomes than the white non-Hispanic population. The infant mortality rate for black non-Hispanic is about two and a half times that of the white non-Hispanic population. The percentage of low birth weight infants for black non-Hispanics is nearly double that of the white non-Hispanic infants. The percentage of black non-Hispanic and Hispanic mothers who received adequate prenatal care or who received prenatal care in the first trimester is much lower than the white non-Hispanic mothers. The percentage of mothers receiving late or no prenatal care is much higher for black non-Hispanic and Hispanic mothers compared to white non-Hispanic mothers. The percent of black non-Hispanic mothers who initiated breastfeeding is well below that of the white non-Hispanic mothers.

This information has helped to guide the development of the newly revised State Performance Measures and will be used to determine the judicious allocation of scarce Title V resources.

#### Geography

In Indiana, 70% of the population lives in a metropolitan area while 30% lives in a rural area. According to the Indiana Rural Health Association, rural communities have higher rates of chronic illness and disability and poorer overall health status than urban communities. Rural residents tend to be older and poorer than urban residents. Eighteen percent of rural residents are over 65 compared to 15% of urban residents and more rural residents live below the poverty level compared to urban residents.

Chronic conditions such as heart disease and diabetes are more prevalent in rural areas. Injury-related deaths are 40% higher in rural communities than in urban communities. Cancer rates are higher in rural areas. People living in rural areas are less likely to use preventive screening services, exercise regularly, or wear safety belts. These disparities among rural and urban Hoosiers may be caused by a number of reasons including:

Transportation--Many individuals lack access to treatment because appropriate transportation is too expensive, limited by weather factors, or because the patient is too sick to use the options that are available.

Lack of Providers --Residents of rural areas have less contact and fewer visits with physicians. Although 20% of Americans live in rural areas, only 9% of the nation's physicians practice in rural areas and only 10% of specialists practice in rural areas. In addition, 81% of urban counties and 98% of rural counties in Indiana fail to meet the national benchmark for an adequate ratio of primary care specialists per 100,000 population that affects services to children with special healthcare needs. There are 6,000 unfilled nurse positions in our hospitals. Both urban counties (65%) and rural counties (87%) fail to meet the U.S. benchmark for an adequate ratio of RNs per 100,000 population. Indiana has a shortage of 1,000 primary care physicians. If current trends continue, we will need almost 2,000 additional primary care physicians and 20,000 registered nurses (RNs) in Indiana by 2020.

Lack of Services-- Nationally, many rural hospitals have negative operating margins and, from 1984 to 1997, over 500 rural hospitals closed. Several counties in Indiana, such as Pike and Crawford counties in southwest Indiana, do not have a hospital and a number of areas in Indiana have limited or no trauma services at all. In west central Indiana (this geographic area includes Indiana to the Illinois state line on the west, Lebanon on the north, Sullivan on the south, and Bloomington/Indianapolis is on the east), Hoosiers have to travel more than 50 miles to a trauma center.

Limited Services--Rural residents are more likely to report that their provider does not have office hours at night or on weekends.

Insurance--One national study found that almost 20% of rural residents were uninsured compared with 16% of urban residents. Rural residents under 65 are disproportionately uninsured. According to the National Association of Community Health Centers, Indiana had 18 Federally Qualified Health Centers (FQHC) and 86 delivery sites in 2008. These FQHCs saw a total number of 218,738 patients seen in 2008. Of those patients, 4,526 were migrant/seasonal workers and 8,810 were homeless. On average, 42% of clients were uninsured, 40% had Medicaid and 5% were Medicare clients. Twenty-nine percent resided in a rural area.

#### Urbanization

Since the 2000 Census, the population has increased 7.2% in the U.S. and 4.4% in Indiana. Within Indiana, metropolitan areas experienced population gains, while other areas experienced population declines. The fastest growth during both time periods was in the Indianapolis metropolitan area. (Urban Institute and Kaiser Commission on Medicaid and the Uninsured)

Urbanization can have a serious impact on health and many of the negative impacts are suffered by the poor and minorities in greater disproportion. Urbanization is associated with changes in diet and exercise that increase the prevalence of obesity with increased risks of Type II diabetes and cardiovascular disease; vulnerability to sexual abuse and exploitation; and separation from social support networks. Many of these conditions affect the most vulnerable segment of the population - women, children and the elderly.

Environmental contaminants, although not restricted to urban settings, can alter the reproductive process and increase the risk of abortion, birth defects, fetal growth and perinatal death. Particularly in cities, motor vehicles are an important source of air pollution and studies in Indiana are associating pesticides in water with poor birth outcomes. Children are especially susceptible to disease in an urban environment. Not only can they suffer from overcrowding, poor hygiene, excessive noise, and a lack of space for recreation and study, they also suffer from stress and violence that such environments create.

Many of the ill effects of urban life affect people from all incomes. Although most people living in the city take basic public services such as drinking water supply, housing, waste disposal, transportation, and health care for granted, these services are often either deficient or nonexistent for the poor.

#### Private Sector Title V Service Delivery Challenges

The three private sector challenges in providing Title V services are (1) lack of providers who accept Medicaid reimbursement, (2) lack of cultural competency, and (3) location of services.

**Medicaid Providers** -- Indiana has a risk based managed care system for all MCH populations on Medicaid. Providers in some counties have refused to participate in Medicaid reimbursement for pregnancy and infant care until the infants are on CHIP. These counties tend to have poorer pregnancy outcomes.

A serious challenge in Indiana over the past few years is not only the number of physicians who do not accept Medicaid reimbursement but also a flawed Medicaid enrollment system that has left many eligible women and infants without insurance coverage throughout the pregnancy and critical first few months of age. In an effort to overcome enrollment challenges for pregnant women, Indiana Medicaid began Presumptive Eligibility (PE) on July 1, 2009. Even so, there are areas of the state where providers are less likely to accept Medicaid reimbursement. Of 92 counties, five have no providers participating in Presumptive Eligibility. Due to the small numbers of prenatal care providers participating in presumptive eligibility, twenty-two (22) counties have lower numbers of pregnant women enrolling in prenatal care.

**Lack of Cultural Competency** -- Lack of cultural competency has played a role in driving black-to-white perinatal disparities higher. In 2006, three counties had a black infant mortality rate greater than 30 per 1,000, approaching third-world statistics. MCH is targeting 5 counties in Indiana that have 80% of the black population and the highest disparity issues. MCH has worked with these counties to increase the cultural competency knowledge of providers and funded programs to address disparate issues.

To address these disparities, MCH is utilizing a life course perspective to impact change. For Indiana to make a difference in black disparities, MCH must work at the neighborhood level to educate and empower high risk populations that encounter cultural barriers to equitable health care services. MCH has been collaborating with the ISDH Office of Minority Health, the Indiana Minority Health Coalition (IMHC), and local minority health coalitions in the five disparity counties. The Indiana Perinatal Network (IPN) and the IMHC both provide agency cultural competency training.

Immigrant populations are also facing barriers to healthcare. An increasing Hispanic population is facing barriers to care from lack of insurance, interpreters, and educational materials and forms that are translated into Spanish. Hispanic centers around the state do not have the capacity to assist all Hispanic families in need.

Indiana also has the largest Burmese population outside of Burma than anywhere else in world. While there are services in place to help this population, they may not be adequate to ensure the Burmese have access to culturally appropriate healthcare services.

**Location of Services** -- Indiana's counties are all autonomous. Efforts in the past to regionalize health systems were not accepted. This has led to lack of accessible services for all Title V populations. The majority of Indiana's primary care physicians are located within 5 counties. Seventeen counties are without a hospital. The only two specialty children's hospitals are both located in Marion County (Indianapolis). Families in some parts of the state must travel long distances to receive specialty care during pregnancy and for children. A large population of pregnant women and children seek health care services in four neighboring states -- Illinois, Ohio, Kentucky and Michigan. Service in the State of Indiana may improve because three large healthcare systems in Indianapolis are buying hospitals around state and providing an increase in services in some counties. MCH will address regionalization of hospitals providing perinatal services over the next five years. /2013/As of 2012, 29 of the 92 Indiana counties do not have a delivery hospital./2013// /2014/ As of 2013, 28 of the 92 Indiana counties do not have a delivery

hospital. //2014// ***2015/ As of 2014, 29 of the 92 Indiana counties do not have a delivery hospital. //2015//***

#### Current and Emerging Issues

In terms of MCH, an overriding issue is the effectiveness of our interventions and programs. Many of our health status indicators and health outcome indicators over the past years have remained stagnant or gotten worse. While Indiana is not alone in this phenomenon, it is an issue that we are in the process of addressing. First, we have renewed our commitment to improve the health and well being of mothers, children, and women of childbearing ages. Second, we have rethought our strategies and are focusing on evidence-based interventions. Third, we are defining and implementing a life course health perspective and intend to partner with many more providers and communities to make a difference. With a fresh eye and renewed energy, we are moving in a new and exciting direction.

From our five year needs assessment, we have identified 10 top State priority issues -- two are continuing, three have been modified, and five are new. The following paragraphs provide a brief overview of these issues. More discussion on these issues can be found in the State Performance Measures and the Five Year Needs Assessment.

Pregnancies occurring at short interval are an important issue because they increase the risk for adverse outcomes such as low/very low birth weight babies, premature births, and small for gestational age infants. Activities to address birth spacing will include training providers and clinic staff on preconception best practices and new family planning methods; application of quality improvement techniques to increase opportunities for screening and health promotion to women, before, during and after pregnancy; and integration of reproductive health messages into existing state health promotion campaigns.

Although breastfeeding rates have consistently increased over the past several years to an overall rate of 66.5%, Indiana's breastfeeding rate still falls below not only the national average but also the Healthy People 2010 goal of 75%. Black women, in particular, have low levels of breastfeeding rates. Efforts to increase the rates of breastfeeding in Indiana during the next five years will focus on continued collaboration with state-wide groups to support local coalitions, initiation of a recognition program acknowledging Baby Friendly Hospitals, and collaboration with partners to build tiers of support for breastfeeding from community drop-in centers providing support to mothers to education on breast milk storage for day care centers. /2012/ Indiana's breastfeeding rate increased to 67.1%.//2012// /2013/ Indiana's breastfeeding rate increased to 69.9% in 2009.//2013// ***2015/ In 2013, Indiana developed a model breastfeeding hospital policy template as well as a local breastfeeding resource directory. Indiana is in the process of developing a comprehensive statewide strategic plan that will involve clinical, community, and state and local government entities to address our consistently low initiation, duration, and exclusivity rates. Indiana's breastfeeding initiation rate decreased to 63.6% in 2010. //2015//***

Two problems concerning infants require a special focus: (1) prematurity rates, and (2) accidental suffocation under one year of age. Although premature birth rates are approximately at the national average, prematurity rates for blacks are more than double that of the overall rate. Creation of a statewide plan that addresses prematurity issues is proposed with the Preterm Birth Steering Committee, which is driving system change through policy, standards and tools. Increasing both public and provider awareness as to all aspects of prematurity is also a goal.

The infant mortality rate for 2007 was 7.5 deaths per 1000 live births, higher than the Healthy People 2010 goal of 4.5 deaths. Reducing the number of suffocation deaths in infants will impact this mortality rate. MCH activities to impact this number will also include communication of safe sleep practices, updates to nurse managers/nursing staff, and provision of parent education. MCH will also work with First Candle, Indiana Perinatal Network (IPN), and local community organizations in the four largest counties to conduct training and educational sessions. /2013/



Indiana's infant mortality rate increased to 7.8 per 1000 live births in 2009.//2013//  
 /2014/ Indiana's infant mortality rate fell to 7.7 in 2011 (provisional). //2014// ***/2015/ Suffocation deaths continue to be a contributor to our overall infant mortality rate in Indiana. Since summer of 2013, ISDH has worked collaboratively with Department of Child Services' Permanency Program regarding safe sleep. They currently have a contract with Indiana University to provide safe sleep education and oversight of the Cribs for Kids program through June 30, 2014. Their PEDs grant provides funding for cribs for the Cribs for Kids program and we provided funding for cribs through the PPASS grant last year for at-risk teen parents. Through this on-going collaboration, we have decided to eliminate the outsourcing of the safe sleep program and ISDH will be hiring a Safe Sleep Coordinator by July 1, 2014 to work between both agencies to provide statewide education on safe sleep in accordance with the ISDH infant mortality plan and to provide oversight of the Cribs for Kids program for DCS. //2015//***

Concerns involving children and adolescents involve lead poisoning, sexually transmitted infections (STIs), obesity, and social-emotional health of very young children. Although the number of confirmed cases of lead poisoning in children (below age 72 months) has declined, lead poisoning remains a silent menace that can cause irreversible damage. MCH will continue to work with Medicaid to increase the number of children screened and work with Indiana Lead and Healthy Homes Program (ILHHP) to increase the number of homes remediated. Reduction in the number of STIs is another state objective. Strategies to reduce the STI numbers include providing education and materials to providers treating adolescents, conducting a needs assessment to determine barriers to condom use among adolescents in high-risk populations, and partnering with the Family Health Council to increase screening for STIs. /2014/ In 2012, Indiana had the highest increase in teen traffic deaths in the country. The numbers of 16- and 17-year-old driver deaths in passenger vehicles in the United States were higher for the first six months of 2012 than in the first six months of 2011. Deaths of 16-year-olds increased from 86 to 107 (24%), and deaths of 17-year-olds increased from 116 to 133 (15%). For both ages combined there was a 19% increase in driver deaths. However, Indiana had the highest increase of any state in the country at 13 percent. Three fatal crashes happened in the first six months of 2011 compared to 16 in the first six months of 2012. Indiana drivers education programs are intending to review and possibly adopt the 45 hours classroom/10 hours driving criteria to combat this emerging issue. //2014//

Obesity in high school age children is also a state concern. Recent data indicates that 13.8% of youth have a BMI greater than the 95th percentile for their age and sex. MCH will be partnering with the Division of Nutrition and Physical Activity in the deployment of the Indiana Healthy Weight Initiative that targets increased consumption of fruits and vegetables, decreased consumption of sugar-sweetened drinks, and increased physical activity. /2013/ In 2011, the number of youth in Indiana with a BMI greater than the 95th percentile for their age and sex increased to 14.7%.//2013//

Addressing issues pertaining to the social-emotional health of children under the age of 5 is also an initiative. Foremost among these issues is the lack of qualified service providers to treat children in this age bracket. Children at risk for social, emotional, and behavioral problems include cases of neglect, homeless children, children of refugees/immigrants, and children of deployed military personnel. The proposed state initiative targets capacity building to increase the number of service providers qualified in this area. ***/2015/ The age range for addressing social-emotional health of children has changed. Our Early Childhood Comprehensive Systems grant focuses on children birth to three and our Linking Actions to Unmet Needs in Children's Health focuses on children birth to age eight. //2015//***

The CSHCS division will be focusing its efforts with families and other partners in two main areas. First, the mission of the Integrated Community Services (ICS) Program started in 2008 within the division of Children's Special Health Care Services (CSHCS) is to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with

Special Health Care Needs (CYSHCN) and their families that are family-centered and culturally competent. This is a new initiative for the Indiana CSHCN program that has traditionally concentrated on reimbursing medical services for children with specific chronic conditions. Indiana was one of six states to be awarded federal funding from HRSA/MCHB to support system improvement for CYSHCN and their families and began working on systems improvement on June 1, 2009. Indiana is addressing objectives that fill gaps for CYSHCN in Indiana in each of the six core outcomes of successful systems of care for CYSHCN while synthesizing the goals into "umbrella" or overarching goals focused on 1) Medical Home Implementation, 2) Transition to Adult Care, and 3) The Indiana Community Integrated Systems of Services (IN CISS) Advisory Committee development in order to sustain the project. /2012/Indiana is working to address IN CISS sustainability through the formation of the Indiana Child Health Improvement Partnership, to be called "CHIP IN for Quality", a model that is self-sustaining through grants and partnerships. //2012//

/2013/The CSHCN Division will continue focusing its efforts with families and other partners to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered and culturally competent. The CSHCN Division continues to provide reimbursement for gap filling direct care medical services for children with specific chronic conditions. Over the past 3 years the CSHCN Division has made significant improvements in the area of QI efforts in Medical Homes; Transition to adult healthcare, work and independence and the establishment of a Child Health Improvement Partnership (CHIP-IN) to continue the work of the IN CISS Project to support and promote QI in Medical Homes and the many systems of care CYSHCN and their families encounter. The CSHCN Division has recently begun working with its partners in an Action Learning Collaborative model to create a statewide strategic plan to address Ease of Use of Services for Latino families with CYSHCN in Indiana. CSHCN will also continue to use the CDC's Act Early, Learn the Signs materials to not only educate families and providers regarding early screening and diagnosis of Autism, but to coordinate community-based service systems for CYSHCN and their families in the state. //2013//

***/2015/ The CSHCS Division continues to incorporate state level work through Indiana's Child Health Improvement Partnership, CHIP IN for Quality, to support system changes necessary to improve quality within the Medical Home and optimize the health and health care of Indiana's children and youth through collaborative, measurement-based, quality improvement initiatives. The CSHCS Division currently provides Title V funding to CHIP IN for Quality to spear-head a statewide developmental screening initiative to ensure early screening and diagnosis of children with neurodevelopmental disorders can be optimized. The goal of the project is to implement community-based, state-wide developmental screening, including autism screening, according to the American Academy of Pediatrics' policy statement in partnership with community partners, families, youth, health care providers, the academic medical center, and the CSHCS Division. The CHIP-IN "SWAT" analysis team visits participating primary care pediatric practices in the identified communities using "academic detailing" to introduce developmental screening and to provide tools and information to improve developmental screening. Weekly data is collected for 18 and 24 months screening and charts are provided of screening progress back to the practices.***

***The CSHCS Division continues to work with its partners in an Action Learning Collaborative (ALC) model for Ease of Use of Services for Latino Families Who Have Children and Youth with Special Health Care Needs (CYSHCN) to address the goals and strategies identified in the created statewide strategic plan for this initiative. The strategic plan developed by the Indiana ALC is comprised of five overall goals divided into three main areas including services, education, and capacity building/sustainability. //2015//***

The second emerging area of focus involves Indiana's CSHCS program reimbursement of providers for direct service expenses related to the CSHCS participants' medical condition. With

the present economic climate the program faces continuing challenges to provide the past level of benefits within the current budget constraints.

## **B. Agency Capacity**

In terms of services during the fiscal year 2010, MCH was able to use Title V grant money to fund 12 family planning projects; five genetics centers (providing information, education and services to families of children with genetic disorders or birth defects); 11 infant health projects (providing primary, direct care services to children from birth to less than one year of age); nine prenatal care clinics (providing direct pre-natal medical care by an OB provider), 11 child health clinics (providing direct medical health services to children); six sites provide adolescent health services (three of them are school based providing direct health care services, education and referrals to high school students); one high risk infant follow-up program (providing follow-up care to newborns who were diagnosed with neurological or developmental problems); 15 prenatal care coordination (providing in-home visiting program to high risk pregnant women); six prenatal substance use prevention programs (providing high risk, chemically dependent pregnant women with education, referrals for treatment, and follow-up); six family care coordination programs (providing assessments, education, referrals, and advocating for families); and four dental projects. The narrative that follows provides some insight into the extensive partnership system that helps to ensure services, at all pyramid levels, to the Title V populations. (Please refer to Section B.2 of the Five Year Needs Assessment for a full listing of all partnerships.)

### **State Program Collaboration with Other State Agencies and Private Organizations**

Collaboration with other state agencies and private organizations is key to continued capacity building to meet the needs of the Title V populations. At the State level, at least two agency partnerships have been pivotal in meeting the needs of the Title V population. These include the Family & Social Services Administration (FSSA) and Department of Education (DOE). Under FSSA, the Office of Medicaid Planning & Policy (OMPP) assists not only with payment issues but also with protocol and policy issues that help to establish uniformity and quality of care for women of childbearing age, pregnant women, children, and children with special needs. Collaboration with the DOE ensures that the needs of children/children with special needs are met in the educational venue. The partnership with DOE also provides an entryway for educational curricula on public health issues such as HIV/AIDS, STIs, and fetal alcohol spectrum disorders.

Partnerships with private organizations provide a mechanism for growing capacity beyond the reaches of government. Especially important are the partnerships with professional organizations in the healthcare industry. Examples include the American Academy of Pediatrics (Indiana Chapter) and the Indiana Academy of Family Physicians, which have been key partners in the Community Integrated Systems of Services project. The Indiana chapter of the American College of Obstetricians and Gynecologists and Indiana Certified Nurse Midwives assist in creation and implementation of prenatal standards of care as well as participating on initiatives such as decreasing prematurity. Organizations, such as the Indiana Perinatal Network and the Indiana Chapter of March of Dimes, are also instrumental in bringing issues on health/healthcare for the Title V populations to the legislative forefront, and disseminating perinatal health information throughout the state.

/2012/ New Partners - MCH is particularly excited about its new partnership with Goodwill Industries of Central Indiana. Specifically, through the Maternal, Infant, and Early Childhood Home Visiting Program, ISDH is funding Goodwill Industries to implement Nurse Family Partnership (NFP) in high risk communities in Indiana. This innovative public / private partnership will be the state's first implementation of NFP. Goodwill will wrap its innovative program, Goodwill Guides (Guides), around NFP. Guides is Goodwill's early childhood initiative. Guides works with the entire family, which in this case would be the family members of the NFP participants to:

1. Provide holistic services such as education, financial literacy, workforce development, and health;
2. Early childhood development by navigating quality childcare options; and
3. Continue a relationship with the family and NFP clients after the NFP program ends after the child's second birthday.

Goodwill is well-positioned in central Indiana and has the capacity to implement such a new and broad-reaching program in Marion County, the most heavily populated county in the state. Goodwill can easily position itself in the high-risk areas identified in Marion County and is able to assist with leveraging MIECHV funds. Once families are through the NFP portion of the program, its program, Goodwill Guides will accept its participants to ensure continuity of support services until the child reaches age 5. //2012//

### State Support for Communities

Limited staff at the State level means that resources must be used in a judicious manner to support the local communities. Dedicated State staff serve as a focal point or clearing house, providing local communities with information and research on evidence-based protocols and best practices. Since staff at the State level are aware of a wide range of programs across the state, Title V staff members also provide a means of connectivity between projects. This connectivity allows the sharing of information concerning successes and challenges in the implementation of a variety of local programs.

One example of an interface with local programs is the prenatal care coordination (PNCC) program. This program develops and coordinates access to community-based health care services for pregnant women and their families at risk for poor pregnancy outcomes. The PNCC project provides outreach and home visiting by certified professionals and paraprofessionals to Medicaid eligible women and some non-Medicaid clients.

One further example of state and local collaboration is the Early Hearing Detection and Intervention (EHDI) project. EHDI screens newborns for possible hearing impairment. Any infants testing positive for hearing impairment receive early intervention services. EHDI coordinates with Indiana First Steps, hospitals, providers, and other local agencies to provide intervention and follow-up services.

MCH also funds the Indiana Family Help Line (IFHL) which provides a means of connecting families with community level services. For example, during calendar year 2009, the top five needs were dental, transportation, food & clothing, health/medical, and financial assistance, respectively. A strong relationship between MCH staff and MCH clinic directors also allows for a sharing of information concerning local participation in community programs such as school wellness projects.

//2012/ During calendar year 2010, the top five information needs were transportation, dental, health/medical, Spanish Services, and Medicaid Services, respectively.//2012//

### Coordination with Health Components of Community-Based Systems

Key health components in community systems include access to care, insurance coverage, prevention initiatives, and a medical home for children with special needs. At the state level, MCH and CSHCS collaborate with the OMPP, in the Indiana FSSA, to ensure a woman's access to prenatal care via the "presumptive eligibility" program. Children's Special Health Care Services (CSHCS) also collaborates with OMPP to provide supplemental medical coverage to families of children with chronic medical conditions. Community-based staff provide feedback to MCH staff concerning strengths and issues associated with these processes. Prevention programs are a key component in addressing issues, especially those associated with pregnancy. Examples of

such initiatives include smoking cessation during pregnancy and prematurity prevention. IPN and the Coalition to Prevent Smoking in Pregnancy (CPSP) are two examples of organizations that provide a conduit between state and local advocates in support of these initiatives.

The medical home is an especially important component for children/children with special needs. Currently, the pediatric staff at Indiana University School of Medicine is working with the Community Integrated System of Services on the medical home learning collaborative. This collaborative involves 9 pediatric and family practice members and is charged with establishing medical homes in these practices and others.

/2012/ The Medical Home Learning Collaborative has now expanded to 18 pediatric and family practices statewide. //2012//

#### Coordination of Health Services with Other Services at the Community Level

Indiana has at least two major mechanisms to coordinate health services with other community services. The IFHL is a centralized clearing house which connects families with services located in their respective counties/communities on a statewide basis. IFHL participates in the Indiana 211 Partnership, a regionalized information and referral service. IFHL is also involved with Connect2Help which provides a forum for discussion/implementation of standards, resources and policies concerning information and referral systems. The second mechanism of coordination of services concerns the contractual agreement with each of the MCH clinics providing services. Inclusion of Memorandums of Understanding (MOUs) with community organizations providing support services is strongly encouraged and reviewed with each clinic grant application.

/2012/ IFHL is also a member of Alliance for Information and Referral Systems (AIRS) which provides guidelines for implementation of standards, resources and policies concerning information and referral systems.//2012//

#### State Statutes Related to Title V Authority

In terms of state statutes, the following summaries present the most recent legislation that affects the Title V populations.

Newborn Screening Law (IC 16-41-17) -- Requires screening for 44 genetic and metabolic conditions.

Universal Newborn Hearing Screening (IC 16-41-17-2) -- Requires newborn hearing screening prior to infants leaving the hospital. This statute also requires appropriate referrals for confirmed positive test results.

Birth Defect Information (IC 16-38-4 and rule 410 IAC 21-3) -- Requires the collection and maintenance of birth defect information. This provides for the creation and support of the Indiana Birth Defects and Problems Registry.

Funding for Children with Special Health Care Needs (IC 16-35-2 and IC 16-35-4) -- Requires provision for and distribution of funds for children with special health care needs.

Workplace Lactation Support (SEA 219; P.L.13-2008) -- Requires government and private employers to provide a private space and access to cold storage for women to express breast milk while at work.

Tobacco Warning During Pregnancy (HEA 1118; P.L. 94-2008) -- Requires all retail outlets that sell tobacco products to post a warning of the dangers of smoking during pregnancy and post the toll-free Indiana Quitline number.

Family Planning Waiver (SEA 572; P.L. 20-2005) -- Requires the OMPP to submit a waiver to the federal government extending Medicaid coverage for up to two years postpartum for family planning services.

Prenatal Substance Use Report (HEA 1314; P.L. 86-2006)--Requires the ISDH to assess the incidence and factors associated with substance abuse use during pregnancy in the State of Indiana.

Prenatal Substance Use Commission (HEA 1457; P.L. 193-2007) -- Establishes a statewide, multi-agency, bi-partisan commission to make recommendations on how to reduce substance use during pregnancy in the State of Indiana.

Cigarette Tax Increase (HEA 1678; P.L. 218-2007) -- Increases the tax on cigarettes and designate funds to support smoking-cessation activities, covering uninsured individuals and immunizations.

Other legislative activities include efforts to implement a smoking ban in public places; however, this effort failed. One highlight in tobacco-related legislation involved the failed attempt to abolish the Indiana Tobacco Prevention and Cessation Agency's Executive Board, dissolve the agency, and transfer the assets of the ITPC to the ISDH a part of SB 298.

As reported in the Indianapolis Star (3/23/10), Governor Daniels suspended future enrollments for childless adults in the Healthy Indiana Plan, blaming the healthcare reform package passed by Congress. Daniels said the state should continue to enroll families for the immediate future so it would not be forced to forfeit federal stimulus dollars.

Based on Senate Act 226, the health finance commission is studying the topic of teen suicide, including the root causes and prevention, during the 2010 legislative session. Finally, House enrolled Act 1320, which controls the selling and purchase of ephedrine and pseudoephedrine, also requires the legislative council to assign study topics on this issue. It was signed into law by Governor Daniels on 3/18/10.

/2012/

SEA 04, suicide prevention

Effective July 1, 2011, SEA 04 allows a school's governing body to adjourn its schools to allow teachers to participate in a basic or in-service course of education and training on suicide prevention and recognition of signs that a student may be considering suicide. The Division of Mental Health and Addiction (DMHA) is required to provide information and guidance to local school corporations on evidence-based programs for teacher training on the prevention of child suicide and recognition of signs that a child may be considering suicide. After June 30, 2013, an individual may not receive an initial teaching license unless he/she has completed training on suicide prevention and the recognition of signs that a student may be considering suicide.

Family Planning Services

Language regarding Indiana's long-standing attempts to implement a family planning waiver was incorporated into SB 461, Health Care Reform Matters, which also stipulates that a state agency may not implement or prepare to implement the federal Patient Protection and Affordable Care Act. Before January 1, 2012, the Office of Medicaid Policy and Planning must apply to the US Department of Health and Human Services for approval of a state plan amendment (SPA) to expand the population eligible for family planning services. The SPA must include women and men, set income eligibility at 133% of the federal income poverty level, and incorporate presumptive eligibility for services to this population. In addition, the law requires OMPP to report on the progress of the SPA to the Medicaid oversight committee during its 2011 interim meetings.

Perinatal HIV

SB 581, HIV Testing of Pregnant Women was passed with widespread support. The law now permits consent by a pregnant woman to have HIV testing to be documented in the pregnant woman's medical chart instead of requiring a written statement of consent. It also requires the issue of general HIV consent to be addressed by a summer study committee.

#### Abortion and Reproductive Health Care Services

National attention has focused on HB 1210, which ends the use of public funds for Planned Parenthood of Indiana (PPIN), prohibits Medicaid payment for PPIN services, sets a 20 week cutoff for abortions, and requires physicians to notify patients of a link between abortion and infertility, fetal pain and numerous other provisions.

On June 1, the US Department of Health and Human Services Center for Medicare and Medicaid Services (CMS) rejected the Indiana Office of Medicaid Policy and Planning (OMPP) request to block Medicaid recipients from receiving care at PPIN, saying that such a provision is in violation of federal law. Indiana has 60 days to appeal the decision if it chooses. In response, state officials have said they will continue to follow and enforce the law, and are seeking guidance from the Indiana Attorney General's office. PPIN and the American Civil Liberties Union have filed suit against the law. Their request for an immediate injunction to cease its enforcement was initially denied, then granted by US District Judge Tanya Walton Pratt while she considers the case.

#### Tobacco and Other Drugs

Efforts to pass comprehensive smokefree air legislation failed once again when a heavily-amended HB 1018, Smoking Ban in Public Places, was voted down by Senate committee. The Indiana Campaign for Smokefree Air will continue meeting over the summer to assess strategies for the 2012 session. HB 1233, State Boards and Commissions, moved the Indiana Tobacco Prevention and Cessation Agency into the Indiana State Department of Health. Tobacco-prevention funds were cut by over \$2 million. The subject of substance use by pregnant women will be examined by a summer study committee, as required by HB 1502.

#### Newborn Screening

In 2011, the Indiana legislature added pulse oximetry to Indiana's newborn screen. Per 16-41-17-2, effective January 1, 2012, all birthing facilities in Indiana will be required to perform pulse oximetry screening on all newborns to detect critical congenital heart defects. The ISDH Newborn Screening Program is working with neonatologists, nurses, pediatric cardiologists, and high-risk obstetricians to finalize the screening protocols; identify any guidelines or recommendations related to purchasing, upgrading, or standardizing pediatric pulse oximetry equipments; and identify the type of data that will be required for reporting to ISDH. //2012//

/2014/ SB 572, Child fatality reviews. Requires the department of health to employ a state child fatality review coordinator to assist the statewide child fatality review committee and assist local child fatality review teams. Establishes other duties for the state child fatality review coordinator. Establishes duties and responsibilities of local child fatality review teams and the statewide child fatality review committee. Requires the following to be paid from funds appropriated to the state department of health: (1) The salary of the state child fatality review coordinator. (2) Expenses for training for the state child fatality review coordinator, members of local child fatality review teams, and members of the statewide child fatality review committee. (3) Other expenses related to the duties of the state child fatality review coordinator. Repeals current provisions concerning local child fatality review teams and the statewide child fatality review committee. Relocates certain provisions that are repealed concerning local child fatality review teams and the statewide child fatality review committee. //2014//

**/2015/ HB 1253, Umbilical cord blood bank. Transfers the umbilical cord blood donation initiative from a nonprofit corporation established by the secretary of family and social services to the state department of health and changes the name from "umbilical cord blood donation initiative" to postnatal donation initiative. Eliminates the nonprofit corporation. Eliminates the duty of the nonprofit board to establish a public umbilical cord**

***blood bank. Establishes the postnatal donation board to assist the state department of health. Provides civil immunity to persons who participate in the postnatal donation initiative. Repeals the provisions related to the conduct of the umbilical cord blood program through the office of the secretary of family and social services and its nonprofit corporation.***

***SB 408, Neonatal Abstinence Syndrome. Per IC 16-18-2 IC 16-18-2-244, "Neonatal abstinence syndrome" and "NAS", for purposes of IC 16-19-16, refer to the various adverse effects that occur in a newborn infant who was exposed to addictive illegal or prescription drugs while in the mother's womb. Before November 1, 2014, the state department, in consultation with the Indiana Hospital Association, Indiana Perinatal Network, Indiana State Medical Association, Indiana Chapter of the American Academy of Pediatrics, Indiana Chapter of the American Congress of Obstetricians and Gynecologists, and Indiana Chapter of the March of Dimes, shall report the following to the legislative council in an electronic format under IC 5-14-6 for distribution to the appropriate interim study committee:***

- (1) The appropriate standard clinical definition of "Neonatal Abstinence Syndrome".***
  - (2) The development of a uniform process of identifying Neonatal Abstinence Syndrome.***
  - (3) The estimated time and resources needed to educate hospital personnel in implementing an appropriate and uniform process for identifying Neonatal Abstinence Syndrome.***
  - (4) The identification and review of appropriate data reporting options available for the reporting of Neonatal Abstinence Syndrome data to the state department, including recommendations for reporting of Neonatal Abstinence Syndrome using existing data reporting options or new data reporting options.***
  - (5) The identification of whether payment methodologies for identifying Neonatal Abstinence Syndrome and the reporting of Neonatal Abstinence Syndrome data are currently available or needed.***
- (b) Before June 1, 2015, the state department may establish one (1) or more pilot programs with hospitals that consent to participate in the pilot programs to implement appropriate and effective models for Neonatal Abstinence Syndrome identification, data collection, and reporting determined under this chapter.***

***HB 1358, An Act to Amend the Indiana Code concerning health.***

***Section 18. Per IC 16-37-2-5 amendment, effective July 1, 2014, a local health officer may accept a certificate of birth presented for filing not more than twelve (12) months after the birth occurred if the attending physician, certified nurse midwife, certified direct entry midwife, or other person desiring to file the certificate states the reason for the delay in writing. This statement shall be made a part of the certificate of birth.***

***Section 19. Per IC 16-38-4-1, effective July 1, 2014, the age range of autism spectrum disorder within the list of birth problems has been extended to include an individual at any years of age.***

***Section 20. Per IC 16-38-4-8, effective July 1, 2014, the state department shall be required to inform the individual with problems at any age or the individual's parent at the time of diagnosis, if the individual's disorder is an autism spectrum disorder, about physicians and appropriate state and community resources, including local step ahead agencies and the infants and toddlers with disabilities program. The state department shall record in the birth problems registry at any age if the individual is diagnosed with an autism spectrum disorder and information reported to the state department by the office of the secretary under IC 12-12-9-3 concerning a child who is less than five (5) years of age and diagnosed with a visual impairment of blindness. Concerning an individual who is at least eight (8) years of age and diagnosed with an autism spectrum disorder, the state department is not required to do any of the following:***



- (1) Report information to the federal Centers for Disease Control and Prevention.**
- (2) Confirm the individual's diagnosis.**
- (3) Verbally inform an individual of the information available to them.**

**Section 21. Per IC 16-38-4-9, effective July 1, 2014, An individual or entity who recognizes a birth problem in:**

- (1) a child after birth but before the child is five (5) years of age, if the child is diagnosed with a fetal alcohol spectrum disorder;**
  - (2) an individual at any age, if the individual is diagnosed with an autism spectrum disorder; and**
  - (3) a child before the child is three (3) years of age for any birth problem diagnosis not specified in subdivisions (1) and (2);**
- shall report the birth problem to the registry not later than sixty (60) days after recognizing the birth problem. Information may be provided to amend or clarify an earlier reported case. //2015//**

State Title V Capacity

Preventive and Primary Care Services for Pregnant Women, Mothers, and Infants

MCH and CSHCS are committed to providing quality, comprehensive, holistic health care to low-income pregnant women, mothers and infants in community settings and decreasing infant mortality and low birth weight babies. In FY 2010-2011, Indiana Title V funded 36 direct care services in 24 counties. These direct care services provided care to 26,016 pregnant women, 89,607 infants, 73,030 children 1 to 22 years of age, and 6,551 children with special health care needs.

MCH provides the "Free Pregnancy Test Program", a population-based enabling service intervention to reduce infant mortality and encourage women to access early prenatal care. The program provides agencies serving women of childbearing age free pregnancy tests to use as an outreach service for hard-to-reach clientele. The program also helps pregnant women obtain early prenatal care through Hoosier Healthwise, WIC, and prenatal care coordination. Furthermore, it assists the entrance of non-pregnant adolescent women into the health care system through Hoosier Healthwise enrollment. Currently, Free Pregnancy Test program is in 58 counties and served 14,382 clients in FY 2009.

//2012//From October 1, 2009 to September 30, 2010, clinics funded to provide free pregnancy tests offered a total of 9,438 tests. Of these tests offered, 60.5% were offered to patients who were White; 21.5% to patients who were Black; 10.4% to patients with an Unknown Race; 2.4% were offered to patients who were Asian/Pacific Islander or American Indian; and 19.5% were offered to patients who were Hispanic / Latino. In addition, nearly 2 in 3 patients (61.4%) were at or below 150% of the poverty level. Over 1 in 3 (34.2%) were not high school graduates and nearly 1 in 10 (9.4%) were currently attending high school. Over 8% of all patients were under the age of 17, while 45.2% were between the ages of 18 to 24 and another 25% were between the ages of 25 and 30. Of all tests, 40.1% were Positive while 57.7% of the tests were Negative. Of all patients, two out of three (66.3%) had no insurance. One in three patients (33.9%) was a smoker. Over 8,200 referrals were made as a result of the pregnancy tests. The FPTP is one of the most cost effective ISDH Title V programs considering the volume of data generated by each test that is not available elsewhere. FPT's provide the "proof of pregnancy" required by Medicaid for enrollment in PNC much earlier in their pregnancy than they would have without it. With only \$8,677 available for this program during the project period, an incredible number of women were served and invaluable data was gathered regarding low-income women of childbearing age who engage in sexual activity.//2012// //2014/ MCH spent \$6,277 on 9,700 tests in 95 sites throughout Indiana in FY11 and \$6,137.50 on 9,550 tests in FY12. The demographics are unchanged. Referrals were made to prenatal care coordination if the test was positive or the woman would like to become pregnant. Referrals were made to reproductive health professionals if the woman

wanted more information on family planning options, and to other social workers, smoking cessation programs, and other specialists as appropriate. For a small amount of funding, MCH continues to provide this highly cost-efficient outreach program that also provides data for future direction of preconception/prenatal care for low-income sexually active women of childbearing age.//2014// ***/2015/ In FY13, MCH paid \$7,676.98 for pregnancy controls and tests from Stanbio and distributed these to 28 separate sites. We are reexamining the process for reporting to simplify and integrate it with our prenatal care coordination online portal and we also seek to find ways to publicize and expand this worthwhile program. //2015//***

MCH provides enabling services for pregnant women, mothers and infants through grants to five prenatal care coordination programs. Prenatal care coordination grantees provide outreach and home visiting by certified professionals and paraprofessionals to Medicaid eligible women. The program targets pregnant women with low incomes and pregnant women who are high-risk because they reside in medically underserved areas. MCH staff also oversees the training and certification of community health workers to assist prenatal care coordinators.

MCH supports pyramid level enabling services for smoking, alcohol and drug use cessation in the Prenatal Substance Use Prevention Program (PSUPP). MCH receives money from the State's Division of Mental Health and Addiction (DMHA) to fund all or part of eight of the grantees, Tobacco Settlement funds three grantees and Title V funds all or part of five grantees, including one site that receives partial funding from both Title V and DMHA. ***/2015/ In October 2013, the PSUPP program was been replaced by the evidence-based Baby and Me-Tobacco Free program. Despite the good work that PSUPP provided, Indiana's smoking rates during pregnancy remain to be some of the worst in the country in 2011, with almost 17% of all pregnant women smoking during their pregnancy and almost 30% of all Medicaid moms smoking during their pregnancy. Therefore, MCH is granting money to 8 organizations across the state to implement Baby and Me-Tobacco Free and we're also funding a Quality Improvement project with Indiana University to determine return on investment with incentive-based smoking cessation programs. //2015//***

/2012/ MCH now operates three new federally-funded programs that serve women of childbearing age and their families: (1) Social Immersive Media for Lifecourse Education [SIMPLE]; (2) Pregnant and Parenting Adolescent Support Services [PPASS]; and (3) Maternal and Infant and Early Childhood Home Visiting Program [MIECHV].

SIMPLE is an innovative social marketing approach to increase public awareness of the importance of integrating the life-course perspective into preconception planning and care. To improve health and pregnancy outcomes, new and expectant parents must first be aware of protective and risk factors that may affect birth outcomes. The purpose of this program is to (1) increase knowledge of life-course perspective for pregnant and parenting women and their families; (2) increase knowledge of life-course perspective for the local community; (3) decrease poor birth outcomes utilizing a social immersive interactive media tool to teach healthy habits; and (4) expand public health professional's ideas of teaching tools to include new technology.

At the foundation of the SIMPLE project is SNIBBEInteractive's InfoTiles (<http://www.snibbeinteractive.com/platforms/socialscreen/products/infotiles>). With InfoTiles, people can browse large amounts of information in a playful social game. People move a game tile over a series of boxes. When they rest the selection box, the tile turns over and reveals video, images, and text. By making information browsing a game, people are engaged and excited to explore all the information. SIMPLE targets populations on all levels of the Social Ecological Model - the individual new or expectant parent, those that provide social and medical support to the new or expectant parent, communities identified as high risk, and the general population.

SIMPLE brings public health initiatives to the communities of Indiana through the use of a social media website and an interactive media device. The evaluation piece of this unique and innovative project will provide MCH with necessary data to assist the state of Indiana in reducing

adverse health outcomes among first time parents and their children by increasing the knowledge that the public holds on conception and the course of pregnancy. The SIMPLE tool will be used at local community health fairs, baby expos and exhibits, health centers, and other nonprofit and for profit resources used by expecting parents, their family members, and their friends. SIMPLE truly acts as a public health program which enters into the community instead of asking the community to come to us-- "mobile" information in this sense. This program reaches mothers, fathers, family members and friends of those expecting a new baby across the state of Indiana. The SIMPLE tool is being taken into 5 Indiana counties which represent the urban, rural, and suburban populations during the course of its three year federally funded research stage. Specific counties were chosen to help us better understand how social media outlets and interactive devices impact the knowledge that one can gain on public health through such formats.

The purpose of PPASS is to work with community partners to implement evidence-based programs at high schools and community organizations to provide assistance and support for pregnant and parenting teens. MCH developed a survey to assess perceptions of stakeholders to identify community perceptions, partnerships, resources and challenges related to the population of pregnant and parenting adolescents. All 92 of Indiana's counties were represented in the responses. There were 197 respondents who began the survey and 137 who completed the survey. Results from the web-based survey supported that stakeholders felt many services available to pregnant and parenting teens were lacking or missing.

MCH works in collaboration with community partners to increase public awareness about Indiana's Early Childhood Comprehensive Systems (ECCS) project, Sunny Start, and enrollment by pregnant and parenting teens in Text4baby. MCH and its funded partners employ a life course approach to the services provided to pregnant and parenting teens through the PPASS grant opportunity, allowing for needs to be met in areas such as perinatal and child health care, child development, nutrition, adolescent development, case management, education, mental health, domestic violence, and strengthening families. Through this program, at least six sub-grantees will be awarded funding to provide direct services and programs and/or research and evaluation of pilot studies that better assist pregnant and parenting teens in completing school and achieving improved health outcomes. With the PPASS grant, ISDH's MCH division hopes to strengthen infrastructure in the state so comprehensive sets of services are available to pregnant and parenting teens. MCH has created a Life Course Model for the PPASS Program that demonstrates the need to create systems of services involving both traditional and non-traditional partners. Accordingly, MCH is not funding applicants that propose single agency/organization solutions. Rather, MCH is requiring grantees to partner with other service agencies to wrap comprehensive services around a pregnant and/or parenting adolescent and his/her family.

The last of the three grants is the Home Visiting Program (MIECHV) under the Affordable Care Act, to support evidence-based home visiting programs focused on improving the wellbeing of families with young children. Through the Maternal, Infant, and Early Childhood Home Visiting Program, nurses, social workers, or other professionals meet with at-risk families in their homes, evaluate the families' circumstances, and connect families to the kinds of help that can make a real difference in a child's health, development, and ability to learn, such as health care, developmental services for children, early education, parenting skills, child abuse prevention, and nutrition education or assistance. There is strong research evidence that these programs can improve outcomes for children and families and also yield Medicaid savings by reducing preterm births and the need for emergency room visits. In Indiana, the MIECHV program is co-let by MCH and the Department of Child Services (DCS) which is Indiana's Child Welfare Agency. A statewide needs assessment was conducted to find the areas of greatest need for home visiting services.//2012//

//2013/ MCH contracted with the IU Neonatology Division to develop the first "Circles" national resource center. Circles is a program to assist individuals who want to get out of poverty.//2013//  
// /2014/ Circles contract has been transferred from IU Neonatology Division to Goodwill Industries of Central Indiana (GICI) and ends on September 30, 2013. Circles of Indiana plans to

carry on its work after the end of the funding through their relationship with Goodwill. Circles of Indiana will change its name to TalentBridge and Goodwill will assume financial responsibility for the continued operation of TalentBridge. TalentBridge, through its relationship with GICI, will address multi-generational poverty by assisting low-income persons attain financial independence and economic security through a holistic approach, leveraging GICI's assets and capabilities, including:

- Assisting in matching the Participant's skills and interests with one of many careers identified by TalentBridge as growing within the Participant's geographic area (a Hot Career);
- Assisting in developing a plan to attain, and potentially some financial assistance for, any post-secondary credential (a Necessary Credential) that is a prerequisite for his or her proposed career;
- If necessary, assisting the Participant to obtain transitional employment (perhaps with GICI), while the Participant is in the process of attaining a Necessary Credential;
- Upon a Participant's completion of requirements, assisting the Participant to obtain employment in a Hot Career of interest to the Participant (this process is called Placement, defined below);
- Throughout the Participant's time in the Program, and for a period of one year following Placement, providing access to a Goodwill Guide, who will provide long-term, holistic support.

TalentBridge believes this will be one-of-a-kind, leveraging GICI's assets and capabilities, and will have a long-lasting and sustainable effect on poor Hoosiers, particularly those victims of generational poverty, through a combination of assistance in:

- Career counseling and discernment,
- Post-secondary education financial assistance,
- Job placement, and
- Ongoing employment and life skills support. //2014//

#### Preventative and Primary Care Services for Children

MCH provides preventative and primary care for children through grants to 11 child health care clinics and 6 adolescent health care clinics. These clinics provide both direct medical and enabling services. Many of these grantees are community health centers or are a part of a larger health care facility. MCH provides additional enabling services through six family care coordination programs. Family care coordinators are trained professionals who make home visits to coordinate services for high risk families. In addition coordinators provide referrals, education, and support.

#### Children's Special Health Care Services (CSHCS)

Indiana's CSHCS provides supplemental medical coverage to help families of children who have serious, chronic medical conditions, age birth to 21 years of age. The program serves families with an income before taxes no greater than 250% of the federal poverty level. Statewide partnerships include family support organizations, Medicaid, hospitals and providers of medical services. CSHCS has gone from covering a few diagnoses to providing coverage for well over a thousand specific conditions. The caseload has grown from the original 12 to more than 8,500 participants.

//2012/ In 2011, CSHCS is expanding Care Coordination Services at the central state level. The number of enrolled children has fallen from 8,500 to 5,000 due to a number of factors including lack of a central application system, budget decreases and decreased marketing.//2012//

The Integrated Community Services (ICS) Program focuses on building collaborative relationships with agencies and organizations to integrate family-centered and culturally competent service systems for Children and Youth with Special Healthcare Needs (CYSHCN). The ICS Program was awarded a three year (6/1/2009-5/31/2012) HRSA grant to improve access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families.

The Indiana Community Integrated Systems of Services (IN CISS) Project is focused on three primary objectives including (1) implementing Medical Homes within primary care practices throughout the State; (2) transitioning youth with special healthcare needs to adult healthcare, work and independence, and (3) building systems sustainability through the organization of a Statewide Advisory Committee representing CYSHCN, their families, and the organizations that serve them.

//2012/Indiana is working to address sustainability through the formation of the Indiana Child Health Improvement Partnership, to be called "CHIP IN for Quality", a model that is self-sustaining through grants and partnerships.//2012// /2014/ In 2012, CSHCS partnered with CHIP IN for Quality to fund the Developmental Screening Initiative which involves implementing system change by supporting the primary care medical homes to improve developmental screening in Bloomington, IN and the surrounding rural counties. To improve the quality of health care (related to developmental screening with standardized tools and referrals for children (18-42 months), the CHIP IN for Quality team will help pediatric health care providers implement sustainable practice/system change through: measuring the baseline of autism screening, improving the proportion of children receiving autism screening by 30% over 6 months, and increasing the proportion of children with autism who receive a diagnosis before 42 months old.//2014//

ICS partnerships include CYSHCN and their families, family support organizations, Indiana American Academy of Pediatrics (AAP), Indiana Academy of Family Physicians (AFP), governmental, State and local agencies, medical professionals/providers, medical institutions and local communities.

//2012/ The ICS program is working with the Vermont Child Health Improvement Partnership to adopt their model for Indiana.//2012//

Core partners include (1) the IU School of Medicine (IUSOM) that provides a project facilitator, parent consultants, and project evaluator, (2) the Center for Youth and Adults with Conditions of Childhood (CYACC) that provides a website and educational office visits to help youth with special healthcare needs transition to adult healthcare, and (3) About Special Kids (ASK) that provides meeting support and stipends for families and youth.

//2012/Indiana is working with CYACC on training for youth and young adults with chronic conditions who will be trained as leaders for the "Be Your Own Boss" Chronic Disease Self-Management workshop, that will be conducted throughout the state //2012// /2014/ CSHCS partnered with CYACC to update and redesign the state Transition Manual to be distributed to all CSHCS participants, CYACC patients, and all CYSHCN in the state of Indiana. The manual was made available on the CSHCS website and linked to partner websites supporting CYSHCN.//2014//

To enhance the capacity of CSHCS to access family-centered, community based coordinated care, the IN CISS project has recruited nine healthcare practices to participate in a medical home learning collaborative. This project is aiding the nine practices in developing and implementing quality improvement efforts. Teams are participating in biweekly teleconferences and face-to-face site visits. A face-to-face kick-off meeting was held in October 2009 and a follow-up large group meeting was held in May 2010.

//2012/The Indiana CISS project held a second annual meeting in October 2010 and conducted a follow-up meeting with the practices in May 2011. //2012// /2014/ The IN CISS Project was successful in recruiting 18 healthcare practices in a medical home learning collaborative: 9 pediatric practices and 9 family medicine practices. The team was successful in redirecting practices into two evenly distributed self-selected groups of interest within Medical Home chronic care management, specifically asthma, and relational team-based care. The bi-weekly calls to

support the practices focused on these two areas.//2014//

***/2015/ The CSHCS Division continues to partner with families and recognizes that the parent perspective is an integral part of program development and quality improvement for the CYSHCN population. The CSHCS has implemented a Family Advisory Council comprising of 15 parents of CYSHCN from around the state of Indiana. The council fosters a two-pronged approach for family participation. The first is to collaborate with the CSHCS Division to ensure the parent perspective is incorporated into program planning, quality improvement, and policy and procedures processes within the division. The second is to develop their personal leadership skills through training sessions in order to become comfortable and competent in discussing the needs of CYSHCN overall, not just for their own child/children, and with a goal of serving as a model of family leadership and advocacy statewide. //2015//***

### Cultural Competence

In an effort to address health disparities in Indiana, the General Assembly passed legislation creating the Indiana Council on Black and Minority Health (IC 16-46-6 1992) and directed ISDH to create an Interagency Council on Black and Minority Health. This council includes representation from both government and State agencies. According to the Interagency Council on Black and Minority Health's Report for 2008, some of the key issues in minority health include teen pregnancy and entrance into prenatal care in the first trimester. The teen pregnancy rate is significantly higher for minorities and the percentage of minorities who have early entry into prenatal care is much lower than whites.

MCH staff work with the Director of the Office of Minority Health and the Minority Health Epidemiologist on disparity issues such as prematurity, low birth weight, very low birth weight, and infant mortality. MCH also encourages all grantees, especially those in areas with large or growing minority populations, to work with local Minority Health Coalitions to develop culturally competent staff and materials.

MCH funds prenatal care coordination (case management) and support services for pregnant minority women in two of the most populous counties as part of the effort to lower minority infant mortality and disparity. Training in cultural competency is provided by one of MCH's grantees, IPN, on an as requested basis.

The Indiana Minority Health Coalition (IMHC) director serves on the Steering Committee of Core Partners for Early Childhood Comprehensive Systems (ECCS) initiative. IMHC also participates in programs such as "Have a Healthy Baby", "Operation Fit Kids", and "Diabetes Self Management".

MCH also collaborates with local minority coalitions in Indianapolis, Gary, South Bend, Fort Wayne, Elkhart and Evansville to assist with development of local coalitions to address local perinatal disparity issues, conduct town meet

### C. Organizational Structure

The Honorable Mitchell (Mitch) E. Daniels, Jr. (R) was sworn in January 2005 as Indiana's 49th Governor. The Governor was re-elected for his second and final term in November 2008. In February 2005, Dr. Judith Monroe was appointed State Health Commissioner, the first woman to head ISDH. She led the Health Department until her resignation in March 2010 to take a position at the Centers for Disease Control as the Deputy Director and Director of the new Office of State, Tribal, Local and Territorial Support. /2014/ Mike Pence was elected the 50th Governor of the State of Indiana in 2012 and inaugurated January 14, 2013. Prior to being elected Governor, Pence represented Indiana in Congress. First elected in 2000 and earning a sixth term in 2010, he brought his Hoosier sensibility to the table and quickly established a record of serving his

constituents and championing fiscal responsibility, smaller government and economic growth-skills and values he has brought with him to state government service. In Congress, Pence served on the House Judiciary, Foreign Affairs and Agriculture and Small Business Committees. Pence's leadership and legislative accomplishments resulted in him being elected unanimously by his colleagues to serve as House Republican Conference Chairman and Chairman of the House Republican Study Committee. //2014//

The new State Health Commissioner, Dr. Gregory N. Larkin, M.D., FAAFP, was appointed by Governor Daniels as the Indiana State Health Commissioner in March 2010. At that time, he was asked by the Governor to continue the State's progress in immunizing children, reporting and reducing medical errors, and improving the health culture of Indiana. Prior to his appointment, Dr. Larkin served as the Chief Medical Officer for the Indiana Health Information Exchange, which promotes health information technology for the advancement of quality patient and community care. He is a recognized leader in the promotion of health information and technology and will extend Indiana's recognized preeminence in that area. Before joining the Indiana Health Information Exchange as its Chief Medical Officer, Dr. Larkin was the Director of Corporate Health Services for Eli Lilly and Company. During his tenure at Eli Lilly, Dr. Larkin was the company's Global Medical Director managing five domestic health care clinics, the domestic employee and retiree health plan and was the global liaison for the company's world affiliates for occupational and corporate health care. He has been a member of the Healthy Indiana Plan task force, served as Chairman of the Board of the Indianapolis Medical Society and the Indiana Blood Center, and volunteered with many other medical and community organizations. /2014/ Dr. William C. VanNess II, M.D. was appointed as the Indiana State Health Commissioner by Governor Mike Pence on January 14, 2013. Dr. VanNess served as a member of the Executive Board for the State Health Department from 2006 to 2012. Prior to his appointment, Dr. VanNess served as president and CEO of Community Hospital of Anderson and Madison County from 1997 until January 2013. Dr. VanNess has 39 years of health care experience in Indiana, including 24 years in active practice as a board certified family physician. He also has experience in owning and managing nursing homes. Dr. VanNess holds a bachelors degree from Butler University and a medical degree from Indiana University School of Medicine. //2014//

ISDH is one of several major agencies in State government. ISDH has five commissions overseen by the State Health Commissioner and Deputy Health Commissioner (Please refer to the attached organizational chart). Loren Robertson M.S., R.E.H.S. was appointed Deputy Commissioner in June 2009. Prior to his appointment, Loren served as the Assistant Commissioner for Public Health and Preparedness at ISDH. For more than 30 years, he was associated with the Ft. Wayne - Allen County Department of Health before he began his career with ISDH in May 2005./2012/Loren Robertson resigned in May, 2011. Dr. Larkin appointed Sean Keefer as Chief of Staff on April 14, 2011. Prior to his appointment, Mr. Keefer served as Deputy Secretary of State and Chief of Staff in the Indiana Secretary of State's office. Before joining the Secretary of State's office, he served as the Director of Global Health & Science Policy for the American College of Sports Medicine (ACSM). One of his key responsibilities was to spear-head legislative efforts at the state and federal level on various health-related initiatives with the NFL, NCAA, American Academy of Pediatrics and Centers for Disease Control and Prevention, among other organizations. He also served on many committees to promote physical activity and healthy lifestyles, including serving as one of the U.S. liaisons for Rapa/PANA (Physical Activity Network of the Americas), and served as chair of the Media and Policy Committee for the "Exercise is Medicine" initiative which worked directly with the U.S. Surgeon General's office. He also worked with leadership from the Pan American Health Organization (PAHO) to execute a Memorandum of Understanding between ACSM and the World Health Organization to tackle health issues such as diabetes, obesity and built environment in urban settings in North and Central/South America.

Mr. Keefer also served as the Deputy Commissioner for the Indiana Department of Labor under the Daniels' administration. In his role as Director of the State OSHA Consultation program-INSafe Indiana, he managed a team that worked to educate and ensure workplace safety and

health. In 2008, in his role as Director, Indiana was awarded for the first time the US Department of Labor's Excellence in OSHA Consultation Program Award. Additionally, he was co-chair of the state's largest Work Safety and Health conference from 2007-2010. He also served as the Legislative Director and Public Information Officer. //2012// /2014/ Jim Huston was appointed as Chief of Staff on January 28, 2013 by State Health Commissioner Dr. William C. VanNess II, M.D. Prior to this appointment, Jim served as the Executive Director for the Office of Faith-Based and Community Initiatives. He brings extensive knowledge from both the private and public sectors to the State Health Department. Jim began his career working for Governor Robert Orr in several capacities. He has served as Deputy Commissioner at the Bureau of Motor Vehicles and as Legislative Liaison for the Department of Education. Jim also served as District Director for three members of Congress. In this capacity, he worked with community leadership and constituents in need of service with the federal government. Jim received his Bachelor of Science degree in Political Science from Ball State University. //2014//

The five commissions at the ISDH include Laboratory Services, Public Health and Preparedness, Operational Services, Health Care Quality and Regulatory, and Health and Human Services, which is where the Title V Program resides. As of June 2010, Dawn Adams is the Interim Assistant Commissioner of the Health and Human Services (HHS) Commission. HHS includes the Office of Women's Health, Nutrition and Physical Activity, WIC, Chronic Disease, Children's Special Health Care Services (CSHCS) and Maternal and Child Health (MCH). MCH and CSHCS are responsible for administering and coordinating all parts of the Title V Block Grant for Indiana. /2013/ The Operational Services Commission is no longer. The responsibilities of that Commission have been assumed by the Chief of Staff. //2013//

Dawn M. Adams, J.D., has been with ISDH since 2006 and currently serves as the Interim Assistant Commissioner of the Health and Human Services Commission. She was hired as a Staff Attorney in the Office of Legal Affairs and was recruited by the former Assistant Commissioner of the Public Health and Preparedness Commission, Loren Robertson, to serve as his Operations Manager in the fall of 2008. Her work with public health began in 1993 when she worked as an Environmental Health Specialist for the Grant County Health Department. As the Operations Manager, Ms. Adams took on special projects and served as a resource to the division directors for all things "operational" (finances, contracts, legal issues, human resources, IT, etc.). In addition to these duties, she serves as the Preventive Health and Health Services Block Grant Coordinator on behalf of the agency and frequently takes on other special assignments as requested by the Deputy State Health Commissioner. /2013/ Dawn Adams resigned from her position in December, 2011. Ellen Whitt was appointed Assistant Commissioner of the Health and Human Services Commission at the same time. Ms. Whitt previously served as deputy chief of staff and senior advisor for health promotion in the office of the governor, working as liaison to the Indiana State Department of Health (ISDH), Indiana Tobacco Prevention and Cessation (ITPC), and the statewide trails plan initiated by Governor Daniels and managed by the Indiana Department of Natural Resources (DNR). She also participated fully in the development of the statewide obesity prevention plan called the "Indiana Healthy Weight Initiative," serving for a time as the director of the Division of Nutrition and Physical Activity at ISDH. //2013// /2014/ Arthur Logsdon, J.D. serves as the Assistant Health Commissioner for the Health and Human Services Commission. His work at ISDH began in 1979. Over the course of that time he has served as Communications Director, Deputy Director of the Office of Legal Affairs, and as an Assistant Commissioner for regulatory programs. After eight years as President and CEO of the Indiana Health Care Association, and several years consulting in the area of long-term care, Art returned to ISDH in 2011 to direct efforts to develop Indiana's statewide trauma system. In his role as Assistant Commissioner for HHS, Art will continue to oversee the Trauma and Injury Prevention program along with his expanded responsibilities of overseeing other Divisions within the Commission, including MCH. //2014//

Judith A. Ganser, M.D., M.P.H. is Medical Director for Maternal and Child Health, Children's Special Health Care Services and WIC at ISDH. In this position, she is responsible for providing public health leadership, policy development, and medical guidance to programs including



prenatal, child and adolescent health, CSHCS, Genomics Program, PSUPP, Indiana RESPECT teen pregnancy prevention, WIC, Early Childhood Comprehensive System planning and Community Integrated Systems of Service for children with special health care needs (CSHCN). She works with a multidisciplinary professional team and administrative staff. Dr. Ganser received her medical degree from Temple University Medical School and her Masters in Public Health from the University of North Carolina at Chapel Hill. She is board certified in Pediatrics and did a Preventive Medicine residency. Prior to joining ISDH in 1991, she served five years as the Medical Director of the Adolescent Health Program for MCHD. She has also worked as a Pediatrician in a Community Health Center in Pueblo, Colorado and Physician-team leader in School-Based Pediatric/Adolescent Clinics in Dallas, Texas. /2013/ Dr. Ganser retired from ISDH in February, 2011. ISDH has not hired a replacement as of this writing. However, Dr. Joan Duwve, State Medical Director, and Dr. Meena Garg, Director of Chronic Disease, are available to answer questions and address any concerns.//2013// /2014/ Dr. Meena Garg left ISDH in 2013. In 2013, Dr. Ted Danielson became the new Medical Director for Maternal and Child Health. //2014//

In the Health and Human Services Commission, Mary M. Weber, MSN, RN, NEA-BC, became the new Director of the Maternal & Child Health Division in October 2009. Kimberly Minniear became the new Director of CSHCS in February 2010, after serving as the Director of Integrated Community Services since May 2007. Also, in April 2010, James R. Miller, DDS was hired as the Director of Oral Health.

Mary Weber, MSN, RN, NEA-BC, joined ISDH as the Director of the Division of Maternal and Child Health in October of 2009. Prior to joining ISDH, Ms. Weber served in leadership roles related to maternal and child health for over twenty years in both for-profit and not-for-profit corporations. Most recently, she was the administrator for Women's Health for the Clarian Health System in Indiana, responsible for strategic planning, program development, labor management, and overall operational administration. Specific programs included perinatal outreach, childbirth education, Clarian Breastfeeding Center, perinatal bereavement, postpartum home visits, postpartum mood disorders, support groups for mothers of infants and toddlers, and an interpreter-doula program for Spanish speaking maternity patients.

Ms. Weber has been active on many volunteer boards, including IPN, the Indiana University National Center of Excellence for Women's Health, and the Indiana Mothers' Milk Bank, and CKF. She led the effort to establish the Indiana Mothers' Milk Bank, which pasteurizes human milk from screened donors and distributes it to newborn intensive care units throughout the Midwest. Ms. Weber received her Master's degree in Nursing Administration from Indiana University School of Nursing, and is board certified as a Nurse Executive Advanced. /2014/ Robert Bowman became interim Director of Maternal and Child Health on February 18, 2013. Bob Bowman has served five years as Director of Genomics and Newborn Screening Program at ISDH. As Director, he oversees the Newborn Screening Program, the Early Hearing Detection and Intervention (EHDI) program, and Genomics program, including the Indiana Birth Defects and Problems Registry. Previously, Mr. Bowman served as Genetic Specialist for ISDH, where he had direct oversight of the Birth Defects and Problems Registry. Prior to joining ISDH, Bob received a Master's degree in Genetic Counseling from Indiana University, as well as two prior Master's degrees in Secondary Education and Developmental Biology and Genetics from West Virginia University. On August 12, 2013 Bob Bowman became the Director of Maternal and Child Health. //2014//

Kimberly K. Minniear is the Director of the Children's Special Health Care Services (CSHCS) Division. With a BA from Indiana University in Social and Behavioral Sciences, she received the honor of the 2004 Marion County Social Worker of the Year. Ms. Minniear's professional experience includes serving for seven years as a Marion County Family Case Manager at the Department of Child Services, for two years as the Executive Director for the Kokomo Academy in Kokomo, IN., and for five years as the Executive Director of the Carroll County Department of Family & Social Services in Delphi, IN. Among her many accomplishments, Ms. Minniear developed treatment programming for a new juvenile male residential treatment; wrote grants,

secured funding, and established Peer Counseling Program for children; developed programs to enhance parenting skills for at-risk families; served as a member of the Child Protective Team; and is a Certified Child Protective Social Worker. /2014/ Shirley Payne became interim Director of the Children's Special Health Care Services Division on June 10, 2013.//2014// **/2015/ On October 7, 2013, Shirley Payne became the Director of the Children's Special Health Care Services Division. //2015//**

Dr. Jim Miller joined the HHS Commission as the Oral Health Director in April 2010. He has over twenty-five years combined experience in teaching, practice, and dental public health research. He holds D.D.S. and M.S.D. degrees from the Indiana University School of Dentistry, and was a Senior Fellow for five years in the Department of Dental Public Health Sciences at the University Of Washington School Of Dentistry. He also holds a Ph.D. degree in Epidemiology from the University of Washington.

Although not housed in the same commission, MCH works closely with the Office of Primary Care, Lead and Healthy Homes, HIV/STI, Public Health and Preparedness, Immunization, and the Epidemiology Resource Center which are housed in the ISDH Public Health and Preparedness Commission. MCH programs and staff also work closely with the ISDH Operational Services Commission for Finance, Information Technology, (HIPAA) Compliance, Public Affairs, the Office of Minority Health, Legal (and Legislative) Affairs, and Vital Records. **/2015/ The Division of HIV/STI/Viral Hepatitis is now under the Health and Human Services Commission as is the new Child Fatality Review program, which moved from the Indiana Department of Child Services to the Indiana State Department of Health per Senate Bill 572. //2015//**

#### Title V Program Administration

MCH distributes the Title V Federal-State Block Grant Partnership budget primarily through grants to community agencies that provide direct, enabling, population-based, and infrastructure building services that impact the federal and State performance measures.

MCH Business and Grants Management staff manages all contracts, grants, MOUs and MOAs, prepares Grant Application Procedures (GAP), facilitates review of grant and contract applications, and monitors grant and contract expenditures for the MCH Division and the CSHCS Division. This section makes Title V budget and planning recommendations and coordinates all applications for funding, including primary responsibility of preparing Title V Budget and Budget Narrative and Budget. The staffs coordinate all contracting, procurement and programmatic financial tracking and provide clerical support for the MCH Division. Since July 2007, Vanessa Daniels, MPA, MRC, CRC, has managed this Section.

**An attachment is included in this section. IIIC - Organizational Structure**

#### D. Other MCH Capacity

Title V funds enable 86 full-time employees and 34 contractors (16 part-time and 18 full-time for MCH and CSHCS). Title V funds also support one dentist and one secretary in the Oral Health Program, one Information Technology Service (ITS) professional, and two contractual positions in ITS. Outside the HHS Commission, Title V funds support the following staff: one Director, two Environmental Scientists, one Administrative Assistant and one Data Processing Operator for Indiana Lead and Healthy Homes; one Chemist for LRC Chemistry Lab; and four fluoridation staff which include two General Sanitarians, and two Fluoridation Consultants. **/2015/ As of April 30, 2014, Title V funds funded 62 full time state employees, 22 full-time contractors, and 2 part-time contractors in the MCH Division. //2015//**

Mary Ann Galloway joined the MCH Division on April 19th as the Director of Life Course Health Systems. Ms. Galloway has an MPH from the University of South Carolina and received a PMP

certification in 2006. She established and directed the Project Management Office at MPlan, a large health care insurer in Indiana, for three years. Prior to that engagement, she founded and directed a national consulting firm for over 20 years that specialized in healthcare system delivery development, project management and managed healthcare. Her company worked with primary care and other providers in over 20 states who served mothers, infants and children. She manages a team of seven Life Course Health Systems staff. The team oversees the MCH grantees, collaborations and partnerships. They also implement evidence based strategies to improve MCH outcomes with recognition of all socio-economic factors that impact health at the community level.

/2012/ The Life Course Health Systems Team (LCHST) has grown substantially in the past year, primarily due to the award of three new grants. Currently, the LCHST has seven state staff positions and eight contracted positions. Recruitment is underway for two additional contracted positions to help with the Statewide Home Visiting Program. This increased capacity has enabled MCH to improve the reach and depth of programs and services. //2012// /2013/ The LCHST has eight state positions and seven contracted staff.//2013// /2014/ Jeena Siela became Interim Director of Life Course Health Systems on February 8, 2013. She joined the MCH Division on June 7, 2010 as the Youth Risk Behavior Survey Program Coordinator. Since then, she has served in multiple capacities managing the Pregnant and Parenting Adolescent Support Services (PPASS) grant and serving as the State Adolescent Health Coordinator since April 16, 2012. She currently supervises thirteen professional program staff. Jeena received her Master of Public Health degree from the Indiana University School of Medicine and has an undergraduate degree in communication from Purdue University. On July 15, 2013, Jeena Siela became the Director of Life Course Health Systems. The LCHST has seven state positions and six contracted staff. //2014// **/2015/ As of May 1, 2014, the LCHST has seven state positions and two contracted staff, and will be bringing on two additional state or contract employees to oversee the new Safe Sleep Program and the recently vacated Baby and Me Tobacco Free Program. The LCHST will also house two contract nurses with the possible addition of two state nurses to survey the OB and NICU units of all delivering hospitals in Indiana in accordance with the 2012 Indiana Perinatal Hospital Standards, of which we are entering the pilot phase of this certification process. //2015//**

Bob Bowman has served five years as Director of Genomics and Newborn Screening Program at ISDH. As Director, he oversees the Newborn Screening Program, the Early Hearing Detection and Intervention (EHDI) program, and Genomics program, including the Indiana Birth Defects and Problems Registry. Previously, Mr. Bowman served as Genetic Specialist for ISDH, where he had direct oversight of the Birth Defects and Problems Registry. Prior to joining ISDH, Bob received a Master's degree in Genetic Counseling from Indiana University, as well as two prior Master's degrees in Secondary Education and Developmental Biology and Genetics from West Virginia University. /2014/ Bob Bowman currently oversees the Genomics and Newborn Screening Program while also managing his promotion to Director of Maternal and Child Health. Recruitment will be underway to fill this position //2014// **/2015/ On March 1, 2013, Holly Heindselman was hired as a contractor to fill the Genomics and Newborn Screening Director position. On November 12, 2013, she became a state employee and continues to oversee a program of six staff. //2015//**

Andrea L. Wilkes joined ISDH as a Public Health Administrator in MCH in November 2000. She serves as the Project Manager for the Early Childhood Comprehensive Systems grant (Indiana's Sunny Start: Healthy Bodies, Healthy Minds initiative) and supervises two professional staff in the program area of child health. She earned two bachelor degrees (English and Psychology) from Miami University in Oxford, OH. Prior to her employment with MCH, Ms. Wilkes joined State service with the Disability Determination Bureau of FSSA. She served as a manager of a disability claims adjudication unit for many years, during which time she was assigned as a consultant to the Office of the Commissioner at Social Security Administration Headquarters in Baltimore, MD.

/2012/ Charrie Buskirk, MPH joined ISDH as a contractor to serve as the Women's Health Coordinator for women of childbearing ages in October 2010. She has since joined ISDH full-time at 1.0 FTE in April 2011 and now serves as the Public Health Administrator of Women's Health ages 14-44. In this capacity, Ms. Buskirk oversees staff operating the three new federally-funded programs that serve women of childbearing ages: (1) PPASS; (2) SIMPLE; (3) MIECHV. In addition, Ms. Buskirk directs the operations of the Free Pregnancy Test Program and is in the process of ensuring that data collection and reporting as well as ordering methods are streamlined for optimal efficiency. Ms. Buskirk is also responsible for working with statewide partners on the child-spacing state priority measure and to ensure that women of childbearing age in Indiana are receiving adequate and timely preconception and interconception care. Finally, Ms. Buskirk serves as a Title V consultant with ISDH-funded clinics throughout the southern parts of the state. With 10 years of nonprofit programming and fundraising experience, Ms. Buskirk, comes with expertise in procuring and managing federal, state, and private grants and foundation funding after serving as the Director of Grants for a county health and hospital system. After graduating from Purdue University School of Science with a major in Psychology in 2005, Charrie earned her Master of Public Health degree with a concentration in Behavioral Health Science from Indiana University School of Medicine in 2009. /2013/Charrie Buskirk left her position in October 2011. Carolyn Runge was hired as her replacement and began work in June 2012.//2013//

Stephanie Woodcox, MPH, CHES, joined ISDH in 2006 and was promoted to Public Health Administrator in 2010. Ms. Woodcox serves as the State Adolescent Health Coordinator and oversees the Adolescent Health Services (AHS) Program. AHS focuses on serving young people ages 10-24. In this position Ms. Woodcox is the Program Manager for Indiana RESPECT, the state's teen pregnancy prevention initiative; is the state's administrator for the Indiana Family Planning Partnership; is a consultant to school-based adolescent health clinics; and provides leadership to the Indiana Coalition to Improve Adolescent Health (ICIAH) by serving as its facilitator. Ms. Woodcox also supervises the Youth Risk Behavior Survey (YRBS) Coordinator./2013/ Stephanie Woodcox resigned her position in August 2011. Jeena Siela, her replacement, began work in January 2012. //2013// /2014/ Jeena Siela currently oversees the Adolescent Health team while also managing her promotion to Director of Life Course Health Systems. Recruitment is underway to fill this position. //2014// **/2015/ Leigh Kelner, previous Lead Health Educator for MCH, became the interim Adolescent Health Coordinator on August 1, 2013 assuming all of Adolescent Health responsibilities and oversight of the team. Leigh officially became the Adolescent Health Coordinator on September 11, 2013. //2015//**

Beth Johnson joined ISDH in 1993 and currently serves as the State Perinatal Health Coordinator. Ms. Johnson oversees the State Perinatal Quality Improvement that is developing hospital levels of care standards for obstetric and neonatal care, establishing a State Perinatal Database, and addressing a state transport program for mothers and infants. In addition, Ms. Johnson oversees the state Prenatal Care Coordination Program, the State Community Health Worker Program, the Infant Health and Survival Council, and maternal and infant mortality programs.//2012//

Larry S. Nelson, Public Health Administrator, serves as a Team Leader and the Training Manager for MCH. Larry has a B.S. from Indiana State University with a concentration in Public Administration and Political Science. Larry has served in the position of Prenatal Substance Use Prevention Director for one year, CSHCS Team Leader for ten years and in his current position as MCH Team Leader for five years.

/2012/ Larry Nelson, Team Leader and the Training Manager for MCH, retired. His position will be used to add capacity to the Business and Grants Management section. //2012// /2013/Larry resigned in May 2011. Recruitment is underway for his position.//2013//

Vanessa Daniels, MPA, MRC, CRC, became the Business and Grants Management section's

manager and supervises the Assistant Grants Manager and the MCH Administrative Support Section. Vanessa has a Bachelors of Science in Business Management and Human Resource Management. She also has two Masters Degrees: one an MPA in Public Affairs and Nonprofit Management as well as a MRC in Counseling and is a licensed Rehabilitation Counselor with 12 years of grants management and grant writing experience. Additional staff that are a part of the Business Management Section includes an Assistant Grants Manager with over 15 years experience in State government, an Administrative Assistant, three support staff, and one contract support staff.

/2012/ December 2010, Ms. Daniels was promoted to serve as the Director of Grants and Business Management. This change ensures continuity of services provided to grantees of Title V and compliance with all federal and state requirements.//2012// /2014/ Alisha Borcharding, MCH Business Manager, took over all of Vanessa Daniels' responsibilities in December 2012. Alisha has been with the State of Indiana for over six years and has experience writing and managing contracts and sub-grants as well as extensive purchasing experience. Federal grant funding has been involved extensively in those tasks. Alisha's current role is to provide budget oversight for the Maternal and Child Health division and work closely with the agency's finance division to facilitate MCH contracts, sub-grants, and purchasing. //2014// **/2015/ On October 21, 2013, Alisha Borcharding was promoted to Procurement/Payroll Manager within the Finance Division. On April 14, 2014, Laura Betzinger was hired as the new MCH Business and Grants Manager. //2015//**

The MCH Data Analysis Section provides data entry, technical support, and data analysis. The Data Analysis team gathers the majority of the data for the Title V annual report as well as the needs assessment process. The team also contributes to the Data Integration Steering Committee that is responsible for overall data integration and data sharing efforts agency-wide. The data gathering effort involves collecting data from programs and agencies such as all of the MCH projects and clinics in order to provide detailed data required for the Title V Block Grant. The Data Analysis Section is headed by Joel Conner, a Public Health Administrator with a BS in Education and over twenty years of data analysis experience. Joe Haddix, MPH, serves as epidemiologist for Title V programs.

/2012/ Joel Conner who headed the Data Analysis Section also retired. Plans are underway to expand the Data Analysis section to become an MCH Epidemiology, Data Analysis and Surveillance group.//2012//

/2013/ During 2012, MCH developed an Epidemiology Surveillance and Data Analysis team that resides in the same area as MCH program staff. Joe Haddix, MPH, heads a team of five epidemiologists.//2013// /2014/ Joe Haddix currently serves as MCH Epidemiology Division Director and supervises a team of four contracted epidemiologists and two interns. //2014// **/2015/ On December 9, 2013, Kelsey Gurganus transitioned from a contractor to a state employee. Therefore, Joe Haddix supervises a team of one state employee and two contracted epidemiologists. //2015//**

Hope Munn is a social worker who began her career in 2000 after completing her undergraduate studies and earning a Bachelor of Social Work degree from Indiana University. In 2006, she earned a Master of Social Work degree also from Indiana University. Ms. Munn has served in numerous social service settings with various populations including families with low income; veterans with mental illness; persons who are homeless; individuals/families of domestic violence; and children with mental illness and/or behavioral challenges. Ms. Munn's experience as a social worker includes eligibility determination for public assistance programs, provision of in-home counseling to at-risk children/families, and facilitation of care coordination of mental health services. Ms. Munn was recently hired as supervisor of the IFHL and brings social work expertise to the MCH leadership team. **/2015/ On March 21, 2014, Hope Munn resigned as Director of the Indiana Family Help Line. Kelli Smith, Assistant Program Manager, is currently the interim director for the IFHL. //2015//**

The CSHCS Division's management team includes the CSHCS Director, CSHCS Eligibility Manager, CSHCS Claims Manager, CSHCS Prior Authorization Manager, CSHCS Provider Relations Manager and the CSHCS System Manager. In 2007, the CSHCS division added the Integrated Community Services Program and a manager were hired to lead that program. In 2009, the Integrated Community Services Program was awarded a HRSA/MCHB grant to work on systems of care improvement for children and youth with special healthcare needs and their families. The project employs five contract staff to facilitate the work of the project. Two of the team members are parents with children having special health care needs.

#### Role of Parents of Special Needs Children

Parents of children with special health care needs are members of MCH and CSHCS as paid staff and serve in the important role of providing support and leadership to families navigating the complexities of determining diagnosis, treatment, and follow up necessary for their children. Staff support the EHDI Program Director and the Guide By Your Side program. The EHDI program has employed parents via contract agencies since June 2007. Currently, the EHDI program includes three parents as staff members, all of whom are contracted through Indiana Hands & Voices, a parent support organization. One parent works as the Parent Program Coordinator. They oversee the two EHDI parent consultants, is the primary contact for families of children diagnosed with hearing loss through EHDI, and is the coordinator of the Guide By Your Side (GBYS) Program. GBYS is a parent-to-parent mentor program that is offered jointly through EHDI and Indiana Hands & Voices. The primary role of the two EHDI Parent Consultant is to conduct follow-up activities (phone calls and letter generation) to families of the nearly 2,000 children who are referred to EHDI annually after receiving a did not pass newborn hearing screening result. One parent consultant is bilingual (Spanish). The other parent consultant has a child who has been diagnosed in the past year and so is highly familiar with negotiating the current process of hearing loss identification and early intervention.

Additionally two other parent consultants serve on the IN CISS project and provide parent perspective to the Project in developing/selecting educational materials and information and developing policies and procedures. They assist in IN CISS Advisory Committee and Learning Collaborative and training meeting preparation, staffing of the IN CISS Advisory Committees, reviewing Learning Collaborative/Quality Improvement Tool Kit materials, and providing parent perspective training and technical assistance to the quality improvement medical home team practices participating in the Learning Collaborative. Parent consultants assist the project and the practices in the identification, recruitment, and training of parents for participation on practice teams and IN CISS Advisory committee representation. They assist with the development of the agendas for the conference calls and conferences, scheduling practice visits (currently nine pediatric/family practices), and helping collect data.

//2012/ The Medical Home Learning Collaborative has now expanded to 18 pediatric and family practices statewide. //2012//

The About Special Kids (ASK) contract supports parent involvement by using trained and experienced Parent Liaisons to provide peer support, information and referral, and education and training for families of CSHCN. Activities include sending a monthly e-newsletter, developing and sending out educational materials, operating an information "hotline" and a system of follow-up contact with families, conducting training sessions, and assessing the ongoing and changing needs of families with special health needs. ASK, utilizes family input to develop strategies to address issues such as childcare, community resources, early intervention, and health care financing.

### **E. State Agency Coordination**

## Organizational Relationships

Title V staff excel in the area of collaboration. In many cases MCH and CSHCS provide leadership in coordinating efforts among the many public and private organizations concerned with the Title V populations.

Public Health -- The local health departments operate independently in the State of Indiana. However, the ISDH Local Health Department's Outreach Office hosts a monthly conference call and webcast. Agenda topics are gathered from the various commissions at ISDH. The MCH Division uses this opportunity to broadcast updates to the 92 counties throughout the State. In addition, the Outreach Office has established an online communication tool which allows not only a sharing of information but also coordination of events. ***/2015/ In 2013, MCH utilized these webcasts to promote our first annual Infant Mortality Summit, held on November 1, 2013. Marilyn Carter, Infant Mortality Education Liaison, will be using these webcasts throughout 2014 to provide education to local health departments on infant mortality and updates from ISDH. //2015//***

Mental Health & Alcohol and Substance Abuse -- The Division of Mental Health and Addiction (DMHA) provides input to the Social, Emotional & Training Committee of the Early Childhood Comprehensive Systems (ECCS) initiative. For example, DMHA recently awarded \$50,000 to MCH to further the goal of developing a certification program for infant and toddler mental health professionals. DMHA also provides supplemental funding support for seven PSUPP sites and collaborate on the Access to Recovery (ATR) program for pregnant women with substance abuse problems. A representative from DMHA participates in the Indiana Coalition to Improve Adolescent Health (ICIAH)./2013// DMHA and MCH submitted a joint application for Project LAUNCH funds in July 2012. If awarded, the grant will begin in October 2012. //2013//

Education -- DOE is a core partner in the Early Childhood Comprehensive Systems initiative and Indiana Community Integrated Systems of Service (IN CISS) Project Advisory Committee. DOE is also instrumental in the administration of the Youth Risk Behavior Survey (YRBS). DOE participates on the EHDI Advisory Committee and is an integral partner with CSHCS on early and late transition committees. DOE also assists in training and curricula on HIV and sexuality issues for adolescents (This includes a recent MCH-DOE partnership on a recent federal grant application for a new statewide teen pregnancy prevention program). ***/2015/ The 5-year YRBS grant has been moved from DOE internally to ISDH. We applied for Strategy 1 of the funding opportunity in order to pay for Profiles and YRBS data collection; however, we are still collaborating with DOE on obtaining the school samples and letters of support for both surveys. //2015//***

Vocational Rehabilitation/Disability Determination/Rehabilitation Services -- MCH and CSHCS work closely with several divisions in FSSA. The Division of Disability and Rehabilitative Services (DDRS) is the parent agency for First Steps, which partners with CSHCS to create a combined enrollment procedure for children with special needs. First Steps, Indiana's Early Intervention Program, also provides intervention services to children identified by positive Newborn Screening (NBS) and children who do not pass the Universal Newborn Hearing Screening and/or children at risk for later acquired hearing loss. Vocational Rehabilitation Services, under FSSA, also provides referrals and partners with CSHCS.

Medicaid, SCHIP/Social Security Administration -- OMPP, under FSSA, is a key collaborator in the establishment of payment policies and procedures for CSHCS and the development of the Family Information & Resource Directory, Sunny Start Financial Fact sheets, and the Sunny Start Developmental Calendar in both English and Spanish. OMPP has also been instrumental in several prenatal initiatives including PNCC and FCC education for Medicaid Managed Care Organizations; creation of the physician's Notification of Pregnancy forms for prenatal first visits; development of a new Prenatal Risking tool sensitive to psychosocial and nutrition issues; and participation in Quality Improvement Initiatives and setting of performance measures such as

Neonatal Quality Outcomes and prenatal smoking cessation. OMPP is also assisting in the assessment and review of child health with the development of the 'State of the Hoosier Child' report. Working with MCH, IPN, Indiana March of Dimes (MOD), and Indiana Primary Health Care Association, OMPP restructured presumptive eligibility for pregnant women in July 2009.

/2012/ As of July 1, 2011 Medicaid will no longer reimburse targeted case management for Prenatal Care Coordination and HIV Case Management. However, MCH is working to see how this service can be provided through the state's home visiting program or partially funded through Title V.//2012//

***/2015/ As of July 1, 2015, Medicaid will no longer reimburse for early elective childbirths. The new policy means that Indiana Medicaid will not pay a hospital or physician for the delivery of a child prior to 39 weeks gestation that is not medically indicated or occurs naturally. With this policy change, Indiana will become the fourth state to eliminate Medicaid payment for early elective deliveries. About half of all births in Indiana are covered by Medicaid. The Indiana Hospital Association reports that early elective deliveries now make up less than 3 percent of deliveries in Indiana, compared to 11 percent in 2012. //2015//***

Corrections -- MCH partners with the Department of Corrections (DOC) to provide to funding for "Wee Ones Nursery" (WON). WON is located at the Indiana Women's Prison and provides care for children from birth up to 18 months. The goal of the program is to reduce infant placement into foster care and allow an opportunity for bonding and attachment between mothers and their newborns. DOC also offers the Mother and Child Safe Care and Development program and works with Craine House, a step down program for early release of mothers.

Federally Qualified Health Centers -- In 2010, ISDH is funding 46 community health centers (CHCs) that have over 85 locations throughout Indiana. The Office of Primary Care (OPC) provides CHC support with funds from the Master Tobacco Settlement as authorized by the Indiana General Assembly in March 2009. Nineteen community health centers are designated FQHCs. The CHCs are located in 43 of 92 counties. Ten counties have more than one CHC. There are an additional 58 Rural Health Centers in Indiana.

The OPC and MCH share information on statewide needs and how funding is distributed. MCH funds four CHCs for prenatal care coordination. Many CHCs were originally funded as MCH clinics, but they have now developed into comprehensive primary care centers. MCH staff share health information and educational materials with Indiana CHCs through the OPC mailing lists. In addition to sharing of information via staff, activities are also coordinated between MCH, CHCs, and local health departments using a web-based tool.

Primary Care Associations -- The Indiana Primary Health Care Association (IPHCA), advocates for quality health care for all persons residing in Indiana and supports the development of community-oriented primary care initiatives. IPHCA partners regularly with MCH by providing staffing on many MCH committees and councils.

MCH Medical Director works with IPHCA to increase primary care physicians in Indiana through the J-1 Visa Waiver program. IPHCA participates in the development of the Oral Health Coalition.

Tertiary Care Facilities -- The CSHCS program funds an enrollment office at Riley Children's Hospital in Indianapolis, Indiana. CSHCS also trains other hospitals on how to enroll children needing services. Title V also funds five hospital-based genetics clinics throughout the State. These clinics provide both local and outreach services, expanding the effective number of clinics to 13. Services provided at these clinics cover both prenatal genetic counseling as well as pediatric consultation. Prenatal counseling includes the management of high risk pregnancies and provides services such as ultrasound, amniocentesis, and first trimester screening. Several



specialty clinics address issues including bone dysplasia, neurogenetics, fetal alcohol syndrome and Marfan syndrome.

Representatives from the Indiana Hospital Association and representatives from several hospitals have been particularly active on committees and coalitions to improve perinatal outcomes. Hospital medical staff serve on our Prematurity Prevention Initiative Committee. Several hospital staff have committed to assisting in the development of obstetric and newborn levels of care in FY 2011.

Technical Resources and Health Professional Educational Programs and Universities -- IUSOM provides research and evaluation, particularly on adolescent health and behavior, for committees and grantees. Indiana University also participates in the Leadership Education in Neurodevelopmental and Related Disorders (LEND) program. Purdue University provides technical assistance and maintains websites, especially those related to adolescent health. The National Association for Social Workers provides professional certification of prenatal care coordinators. IPN provides professional education pertaining to prenatal care. Organizations such as the Indiana Society for Public Health Education (InSOPHE) provide public health seminars and forums to allow sharing of information and relationship-building.

MCH Medical Director facilitates a month-long elective in Public Health/Preventative Medicine for eight to ten senior medical students per year. In addition, students pursuing a Master's degree in public health frequently perform their internship and project at MCH.

#### Coordination of Title V Programs with Other Federal Programs and Providers

MCH collaborates with numerous providers and many federal programs to ensure that services are available and accessible to members of the MCH population. In addition, MCH partners with other organizations in the sharing of data and the funding of services. Some examples of collaborative efforts follow.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) -- HealthWatch/EPSDT is the coordinated program established by OMPP to provide periodic screening for children under the age of 19. Information concerning Title V and Medicaid providers can be obtained using the toll-free number to the IFHL.

Womens, Infants and Childrens (WIC) -- WIC has numerous partnerships with Divisions within the HHS Commission as well as within ISDH. The IFHL, funded and administered by MCH, provides referrals not only to WIC but also other appropriate agencies. Twenty-one of the WIC clinics house the MCH Free pregnancy testing program. WIC also partners with the immunization program that promotes immunization across the State. The Indiana Lead Safe and Healthy Homes program (ILHHP) collaborate with WIC in the use of the I-LEAD web application to produce consistent and effective risk assessments and environmental information.

Disability -- Both MCH and CSHCS work closely with several divisions in the FSSA. The Division of Disability and Rehabilitative Services (DDRS) is the parent agency for First Steps which partners with CSHCS to create a combined enrollment procedure for children with special needs. First Steps also provides intervention services to children identified by positive Newborn Screening (NBS) and children who do not pass the Universal Newborn Hearing Screening and/or children at risk for later acquired hearing loss. Vocational Rehabilitation Services, under FSSA, also provides referrals and partners with CSHCS.

Family Planning Programs -- The Indiana Family Planning Partnership is a partnership among the Indiana Family Health Council (IFHC), ISDH, the Indiana Department of Child Services (IDCS) and FSSA. These agencies have agreed that the coordinated funding of family planning services in Indiana will increase access to services ensure quality of services, and minimize administrative overhead. All funds have been granted to the IFHC, Indiana's Title X agency. IFHC contracts

with local agencies in locations with the highest risk populations to provide comprehensive reproductive health and family planning services to the citizens of Indiana. The goal of the coordinated funding is to use the public family planning funds as efficiently and effectively as possible to target the women most in need, to provide complete services to all low income women, to maximize Indiana competitive position family planning funding regionally, and to minimize the amount of paperwork for the providers.

OMPP has had a Family Planning Waiver request at the federal level for at least two years. Under the Health Care Reform legislation, states now have the option to expand Medicaid eligibility for family planning services without obtaining a federal waiver. The IPN has shared this new information with representatives from the OMPP, ISDH, and others involved in efforts to secure the waiver's approval. Whether changes can be made under current fiscal constraints is unknown at this time.

//2012/ OMPP has chosen to not pursue the option to expand family planning services without a waiver. The Indiana state legislature addressed Indiana's long-standing attempts to implement a family planning waiver by incorporating language into SB 461, Health Care Reform Matters, which also stipulates that a state agency may not implement or prepare to implement the federal Patient Protection and Affordable Care Act. Before January 1, 2012, the Office of Medicaid Policy and Planning must apply to the US Department of Health and Human Services for approval of a state plan amendment (SPA) to expand the population eligible for family planning services. The SPA must include women and men, set income eligibility at 133% of the federal income poverty level, and incorporate presumptive eligibility for services to this population. In addition, the law requires OMPP to report on the progress of the SPA to the Medicaid oversight committee during its 2011 interim meetings. The bill passed and was signed by the Governor. //2012//

#### Identification of Pregnant Women and Infants Eligible for Title XIX

In 2009, Indiana initiated a presumptive eligibility program for pregnant women who might qualify for Medicaid. The need for the program resulted from a flawed enrollment system that caused long delays in eligibility determination. To participate in the Presumptive Eligibility Program, Indiana requires that health care providers (clinics, OB/GYN, pediatricians, etc) enroll with Indiana Health Coverage Programs (IHCP). These providers must collect basis income information on clients and submit it to Medicaid. They may then provide services which will be reimbursed by Medicaid even if the woman does not turn out to be eligible for Medicaid. The pregnant woman has the responsibility to submit a full application to Medicaid within a certain time period so that she will be enrolled with a Hoosier Healthwise managed care program. MCH assists this mission with its Free Pregnancy Test program. The program focuses on outreach to sexually active women of child-bearing age to improve access to primary, prenatal, and family planning care to impact the State's high infant mortality rate.

//2012/ The presumptive eligibility (PE) process relies on Qualified Providers (QPs) that volunteer to assist pregnant women with the PE Application process. In the first 18 months of the PE program there were 270 Qualified Providers signed up in 66 counties. Over 15,000 pregnant women have been enrolled in PE, about 25% of all pregnant women on Medicaid. Roughly 78% enrolled in PE become Medicaid approved. MCH and IPN are assisting OMPP with promoting the program through newsletters, trainings, requirement for Title V grantees. //2014/ ISDH MCH and Office of Medicaid Policy and Planning will be meeting monthly starting June 2013 to collaborate on common health initiatives, including presumptive eligibility and the sharing of data. //2014// **//2015/ Due to staff turnover at OMPP, these monthly meetings have stopped until new staff are hired to participate in these meetings and our collaborations. However, Joe Moser, the new Indiana OMPP Director, was invited to sit on the Indiana Perinatal Quality Improvement Collaborative (IPQIC) Governing Council and he accepted that invitation. So far, he has attended one council meeting in addition to meeting once one-on-one with Bob Bowman, MCH Division Director. Collaborations continue between our agencies despite staff changes, which is evident in the most recent 39-week hard stop policy that will take**

**effect on July 1, 2014. //2015//**

Department of Child Services - ISDH works closely with the Indiana Department of Child Services (IDCS) for the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). IDCS operates the Healthy Families program throughout the state while ISDH contracts with Goodwill Industries of Central Indiana to implement Nurse Family Partnership program. This partnership ensures that all federally-recognized home visiting programs in operation throughout the state are coordinated for optimal service provision, recruitment of highest-need families, and non-duplication of efforts.//2012//

State Disabilities Determination and Vocational Rehabilitation -- CSHCS works through DDRS in the Indiana FSSA to determine services and rehabilitation for children with special health care needs. First Steps, Indiana's early intervention program, coordinates services for/with CSHCS. Healthy Families Indiana, another early intervention program, identifies, at the time of birth, those families that are at risk of child abuse. CSHCS provides financial support for the training efforts involved in this statewide home visiting program. CSHCS coordinates with developmental disabilities programs primarily through interactions with the First Steps Program and with the UNHS/EHDI follow-up efforts. Coordination with vocational rehabilitation programs is conducted primarily through the database of providers maintained by the IFHL. IFHL provides appropriate referral contacts to statewide vocational rehabilitation offices and agencies.

/2012/ The Sunny Start initiative (MCHB- ECCS) is working collaboratively with other state agencies to increase capacity for social and emotional health of young Hoosier children. This year, the Department of Mental Health and Addiction, the State Head Start Collaboration Office and the Department of Child Services all contributed significant financial funding to the effort. /2014/ Indiana submitted a competitive grant application in April 2013 to the Maternal and Child Health Bureau for funding for the Early Childhood Comprehensive Systems (ECCS) Program at a total of \$140,000 per year for the next three years to mitigate the toxic stress experienced by young children throughout the state. Indiana proposes to build on existing resources to create a coordinated training model that cuts across disciplines and links systems in order to achieve a sustainable system of evidence based and informed supports and treatment services for infant and young children and their families that have experienced trauma or that are at risk for trauma. Indiana received the Notice of Award for ECCS and was awarded \$140,000 for the next three years. //2014//

MCH's Sunny Start initiative has a very active Family Advisory Committee. Among other activities the Family Advisory group is working with the Riley Child Development Center to create a Family Leadership Institute. The Initiative has created a portfolio to track leadership development and a set of leadership competencies (tiered across three levels) that complement the Maternal and Child Health Leadership Competencies.

Indiana is very supportive of state agency coordination and collaboration. In this regard, MCH has initiated two large projects with a number of state agencies. The first project, the Prenatal Substance Abuse Cross Agency Committee, began in August, 2010. The Committee meets monthly to address the significant prenatal substance abuse problem in Indiana. Collaborative state agencies include Indiana State Department of Health (ISDH), Department of Education, Office of Medicaid Policy and Planning, Department of Child Services, and the Division of Mental Health and Addiction. The second project is the Statewide Home Visiting Program. The governor appointed ISDH and the Department of Child Services as co-lead agencies to implement the Indiana Maternal, Infant, and Early Childhood Home Visiting Program. /2014/ Currently, MCH is working with the Division of Mental Health and Addiction (DMHA) to hone in on programming that addresses tobacco use during pregnancy. This relationship with DMHA has been in place since the advent of the Prenatal Substance Use Prevention Program (PSUPP) in 1988, however, PSUPP is ending in the 2013 Fiscal Year. Although this isn't a new partnership with DMHA, the terms of the partnership has evolved to replace PSUPP with evidence based programming

specifically geared towards pregnant smokers in Indiana. New to MCH this in 2013 is a seat on the Attorney General's taskforce to combat prescription drug abuse. This seat provides the opportunity to help formulate solutions to address Indiana's high rate of Neonatal Abstinence Syndrome. The work completed on this committee will be able to build on the aforementioned Prenatal Substance Abuse Committee, which disbanded in 2011. Other collaborating partners in this committee include: (among many others) state legislators, law enforcement, health officials, pharmacy representatives, healthcare providers, educators, hospital groups. //2014//

The Adolescent Health Services Program within MCH has benefited from some unique, new partnerships during FY11. Through the Indiana Coalition to Improve Adolescent Health, which is facilitated by the State Adolescent Health Coordinator (SAHC) in MCH, came the opportunity to partner with a design and marketing firm to help the Coalition produce an adolescent handbook-- a pocket-sized guide for young people about a variety of health issues (dating violence, STIs, binge drinking, stress and depression) and important facts and resource information. Also through the Coalition, the MCH has formed a partnership with a local medical magnet school for high school students. The magnet school is currently participating in a pilot study of the handbooks developed by the Coalition. The Adolescent Health Services Program and MCH also forged a new partnerships with individuals at the Indiana Division of Mental Health and Addiction. The SAHC and other injury-prevention staff at ISDH teamed up to write a large federal grant for SAMHSA funding for suicide prevention among young people. Grant announcements are anticipated in the fall of 2011//2012//

## F. Health Systems Capacity Indicators

### Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2012	other	3.6	2.5	6.7

#### Notes - 2015

2012 Data is provisional.

ISDH-ERC

#### Narrative:

The second indicator, 05B, relates to infant mortality which is a major concern in Indiana. Infant mortality is defined as a death within the first year of life and is represented as a rate per 1,000 live births. The infant mortality rate is calculated by dividing the number of infant deaths by the total number of live births and multiplying by 1,000. After seeing a relatively steady trend between 2005 and 2006, the infant mortality rate decreased to a rate of 6.9 per 1,000 live births in 2008. In 2009 however, Indiana saw another increase in the infant mortality rate of 7.8 per 1,000 live births and then a slight decrease to 7.6% in 2010. This rate is unacceptable and is above the national average. In 2011 the infant mortality rose again to 7.7 per 1,000 live births. Provisional 2012 data shows the rate decreasing to 6.7 per 1,000 live births but is considered an outlier.

The desired outcome for infant mortality is to decrease the number of babies who die before their first birthday. Also decreasing the rates among black and Medicaid-insured is vital to reducing the disparities and also reducing the overall infant mortality rate in Indiana.

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

The mission statement of the Indiana State Department of Health (ISDH) is to "promote, protect, and provide for the public health of people in Indiana". The ISDH vision statement affirms, "The Indiana State Department of Health is committed to facilitation of efforts that will enhance the health of people in Indiana. To achieve a healthier Indiana, the ISDH will actively work to promote integration of public health and health care policy, strengthen partnerships with local health departments, and collaborate with hospitals, providers, governmental agencies, business, insurance, industry, and other health care entities. ISDH will also support locally-based responsibility for the health of the community. ISDH's vision for the future is one in which health is viewed as more than the delivery of health care and public health services. This broader public health view also includes strengthening the social, economic, cultural, and spiritual fabric of communities in our state.

In order to fulfill our mission, MCH and CSHCS continue to strive to meet the performance goals established by national initiatives such as MCHB's National Performance Measures as well as State initiatives, based on the latest needs assessment. The needs assessment results focused on health system capacity indicators and health status indicators, including asthma hospital discharges, Medicaid/SCHIP screening, prenatal care adequacy, low/very low birth weight, fatal/non-fatal injuries, chlamydia rates, dental screening, and adolescent tobacco use.

The needs assessment results have dictated the focus of the State priorities listed in the following section, B. State Priorities. Program and resource allocation issues are determined using the State priorities for guidance. Utilizing the MCH pyramid, program and resource funding has been carefully allocated to cover not only the State priorities but also to cover all four of the pyramid levels.

Outcome measure data for infant mortality, black/white infant mortality disparity, neonatal mortality, post-neonatal mortality, perinatal mortality, and the child death rate are also monitored and reported annually.

Specifically, within the pyramid level of direct medical services, Title V funds programs to provide genetics services, immunizations, dental sealants, sickle cell prophylactic medicine, lead poisoning prevention, direct medical care for pregnant women, infants, children, adolescents, family planning, STD screens, free pregnancy screens, as well as specialty medical services and primary care for CSHCN. Funded Enabling Services programs provide genetics services education, prenatal and family care coordination, newborn screening and referral, sickle cell management, prenatal substance use prevention program (PSUPP), and coordination with Medicaid and WIC in addition to many other programs.

Population-based services that are provided or funded by Title V include the Indiana Family Helpline (IFHL), the Early Childhood Comprehensive Systems (ECCS) program, the Indiana Joint Asthma Coalition (InJAC), the adolescent pregnancy prevention initiative, sudden infant death prevention, dental fluoridation efforts, and fetal infant mortality review. ISDH Infrastructure Building Services include efforts such as the Indiana Perinatal Network; the MCH, NBS and PSUPP data systems; the integration of data systems to facilitate the Indiana Birth Defects and Problems Registry (IBDPR), the Genomics in Public Health and Newborn Screening education efforts and other data analysis efforts for planning and reporting; policy and standards development; planning, evaluation, and monitoring; and quality assurance to MCH and CSHCS grantees.

Progress toward the achievement of our national and State performance goals is reported in Sections C and D following. MCH and CSHCS continue to build on previous years successes.

This year's annual report reflects that for 2009, MCH and CSHCS continue to make progress on eight of the thirteen national performance measures that are not reported through the CSHCN survey. Progress was made on the five performance measures that are reported through the CSHCN survey.

MCH and CSHCS are proposing a new set of State negotiated performance measures (SPM) based on the results of the needs assessment. Two of the new SPM's are identical to the previous SPM's and one has been modified. There are seven entirely new proposed SPM's and some of the previous SPM's are being discontinued. These are enumerated in Sections B and D.

## **B. State Priorities**

Indiana comprehensively evaluated quantitative and qualitative information to develop the State's priority healthcare needs. Indiana allocated \$4,982,945 for FY 2009 in grants to community-based organizations. In the coming year, Title V staff will re-evaluate the distribution of money based on the new state priorities. /2014/ ISDH MCH allocated \$3.4 million for FY 2014 to be dispersed throughout the state with our Title V grantees. //2014// ***/2015/ ISDH MCH allocated \$5.8 million for FY 2015 to be dispersed throughout the state with our Title V grantees. //2015//***

For pregnant women, priority healthcare needs include decreasing smoking during pregnancy, with emphasis on the Medicaid population; increasing the number of black women having adequate prenatal care; decreasing the proportion of births occurring within 18 months of a previous pregnancy to the same mother; and increasing the number of women who initiate exclusive breastfeeding. These priorities are related to State Performance Measures (SPM) 2, 3, 4, 6, and 7, along with National Performance Measures (NPM) 11, 15 and 18. Indiana's capacity to work on these priorities include collaboration with partners at Medicaid, Indiana Tobacco Prevention and Cessation, new initiative development for minorities, educational programs for breastfeeding mothers, and further program expansion within the State Department of Health.

Smoking during pregnancy increases the risk for both a preterm delivery as well as a low birth weight baby. Although the smoking during pregnancy rate has declined in general in Indiana, the rate is still very high for certain populations or locales. Activities to address this issue include providing training and materials to prenatal Medicaid providers; assessing/comparing counties with highest and lowest smoking rates to determine successful anti-smoking strategies; and working with Indiana Tobacco Prevention and Cessation (ITPC)/Indiana Preventing Smoking in Pregnancy Initiative to explore successful cultural and literacy appropriate educational messages targeted to low income women.

During the period from 2002 to 2006, the percentage of women, overall, receiving prenatal care within the first trimester declined from 80.5% to 77.6%. The black percentage decreased from 68.6% to 65.6% over this time period. To address the low level of entry into prenatal care for black women the new focus will target counties having a lower percentage of black women entering prenatal care in the first trimester. Initiatives will include free pregnancy tests, development of a Premature Birth Initiative especially for African American women, and collaboration with the National Fatherhood Initiative on train the trainer workshops.

Short interval pregnancies are an important issue because such pregnancies increase the risk for adverse outcomes, such as low/very low birth weight babies; premature births and small for gestational age infants. Activities to address birth spacing will include training providers and clinic staff on preconception best practices and new family planning methods; application of quality improvement techniques to reduce opportunities for screening and health promotion to women, before, during and after pregnancy; and integration of reproductive health messages into existing state health promotion campaigns

Although breastfeeding rates have consistently increased over the past several years to an overall rate of 66.5%, Indiana's breastfeeding rate still falls below not only the national average but also the Healthy People 2010 goal of 75%. Black women, in particular, have low levels of breastfeeding rates. Efforts to increase the rates of breastfeeding in Indiana during the next five years will focus on continued collaboration with state-wide groups to support local coalitions; initiation of a recognition program acknowledging Baby Friendly Hospitals; and collaboration with partners to build tiers of support for breastfeeding from community drop-in centers providing support to mothers to education on breast milk storage for day care centers,

Two problems concerning infants require a special focus: prematurity rates and accidental suffocation under one year of age. Although prematurity birth rates are at about the national average, prematurity rates for blacks are more than double that of the overall rate. Creation of a statewide plan that addresses prematurity issues is proposed with the Preterm Birth Executive Group driving system change through policy, standards and tools. Increasing both public and provider awareness as to all aspects of prematurity is also a goal. These priorities are related to State Performance Measures (SPM) 1 and 7. Indiana's capacity to work on these priorities include collaboration with the First Candle Project and Indiana Perinatal Network. Indiana has started a premature birth coalition with public and private agencies that increases the State's capacity for these priorities.

The infant mortality rate for 2007 was 7.5 deaths per 1000 live births, higher than the Healthy People 2010 goal of 4.5 deaths. Reducing the number of suffocation deaths in infants will impact this mortality rate. MCH activities to impact this number will center around communication of safe sleep practices/updates to nurse managers/nursing staff and provision of parent education. MCH will also work with First Candle, Indiana Perinatal Network, and local community organizations in the four largest counties to conduct training and educational sessions. /2014/ The number one goal of the agency is reducing infant mortality. Although much has been done already to reduce our infant mortality, our rate has risen to 7.7 in 2011. Therefore, with full support from our Governor and State Health Commissioner, we have some priority areas that we'd like to address in order to reduce our infant mortality rate:

- Implement Levels of Care standards in compliance with the 2012 Indiana Perinatal Hospital Standards.
- Decrease the number of elective deliveries in highest risk hospitals.
- Decrease the number of infant suffocation deaths.
- Ensure pregnant women receive appropriate prenatal care coordination.
- Decrease smoking rates among pregnant women.
- Enact projects that decrease the number of children born with birth defects.
- Ensure that women who could become pregnant are healthy.
- Utilize Perinatal Periods of Risk (PPOR) to better understand and target the factors that contribute to excess infant mortality in individual communities in Indiana. /2014/

***/2015/ Through a collaboration between ISDH MCH and the Indiana Perinatal Quality Improvement Collaborative (IPQIC), much work has been done in implementing the Levels of Care standards in compliance with the 2012 Indiana Perinatal Hospital Standards. The certification process has been designed to be a supportive and provide each birthing hospital with the opportunity to seek certification at the level that is most appropriate for their resources and capabilities. The certification process will be implemented over several years beginning with several pilot sites to test the designed certification process. Once the documentation and onsite process is confirmed as having the desired result, certification will move to a voluntary stage until state regulatory language is in place to move to required status. MCH is also in the process of hiring nurse surveyors to conduct the certification analysis with the pilot hospitals and these staff members should be hired by August 1 for a start date of early September for the pilot phase. Also integral in the success of Levels of Care are perinatal transport standards and implementing the perinatal centers concept. Transport standards have been endorsed by the Governing***



***Council and we are in the process of operationalizing them and developing supporting materials and resources. Similarly, perinatal centers standards were endorsed by the Governing Council and we are in the process of operationalizing them and developing an application process for any hospital wishing the Perinatal Center designation.***

***In early 2014, FSSA's Office of Medicaid Policy and Planning (OMPP) evaluated a request from IPQIC regarding the adoption of a non-payment policy for early elective deliveries and agreed the policy change would help improve the health of mothers and babies. This policy, to take effect on July 1, 2014, is also aligned with initiatives by the March of Dimes, the American Congress of Obstetricians and Gynecologists (ACOG), the Indiana Hospital Association, the state's Medicaid managed care entities and many Indiana hospitals and their medical staffs. FSSA is in the process this week of communicating the details of the policy -- including a list of approved medical indications for a necessary early delivery -- to medical providers statewide. With this policy change, Indiana will become the fourth state to eliminate Medicaid payment for early elective deliveries.***

***Suffocation deaths continue to be a contributor to our overall infant mortality rate in Indiana. Since summer of 2013, ISDH has worked collaboratively with Department of Child Services' Permanency Program regarding safe sleep. They currently have a contract with Indiana University to provide safe sleep education and oversight of the Cribs for Kids program through June 30, 2014. Through this on-going collaboration, we have decided to eliminate the out-sourcing of the safe sleep program and ISDH will be hiring a Safe Sleep Coordinator by July 1, 2014 to work between both agencies to provide statewide education on safe sleep in accordance with the ISDH infant mortality plan and to provide oversight of the Cribs for Kids program for DCS.***

***ISDH MCH currently provides Title V funding to 14 prenatal care coordination (PNCC) sites in addition to 8 new PNCC sites funded through our Infant Mortality grant initiative highlighted last fall at our first annual Infant Mortality Summit.***

***In October 2013, the Prenatal Substance Use Prevention Program (PSUPP) program was been replaced by the evidence-based Baby and Me-Tobacco Free program. Despite the good work that PSUPP provided, Indiana's smoking rates during pregnancy remain to be some of the worst in the country in 2011, with almost 17% of all pregnant women smoking during their pregnancy and almost 30% of all Medicaid moms smoking during their pregnancy. Therefore, MCH is granting money to 8 organizations across the state to implement Baby and Me-Tobacco Free and we're also funding a Quality Improvement project with Indiana University to determine return on investment with incentive-based smoking cessation programs. Since the inception of this program, Anthem Wellpoint Foundation has shown interest in funding additional Baby and Me-Tobacco Free sites specifically in collaboration with CVS pharmacies due to their recent discontinuation of tobacco product sales. March of Dimes is also interested in a possible collaboration between their Centering Pregnancy sites and including Baby and Me-Tobacco Free curriculum within their programs.***

***Lastly, ISDH MCH is in the process of hiring a public relations firm to provide statewide educational messages regarding infant mortality in order to complement the direct services and education we're providing. This public relations firm will work closely with our recently hired Infant Mortality Education Liaison. We're also planning on hosting our 2nd annual Infant Mortality Summit this fall in late October or early November. //2015//***

***/2014/ In addition, we are also participating in the Collaborative Improvement and Innovation Network (COIN) to Reduce Infant Mortality and the National Governor's Learning Network on Improving Birth Outcomes, both of which will provide us with technical assistance and great opportunities to collaborate with other states. We have also responded to the Hoosier Health Care Innovation Challenge (HHIC), proposing the development of an application that could***

perform the following functions: 1) provide important educational information to pregnant women; 2) allow for texting between the expectant woman and her primary care physician (PCP); and 3) alert the expectant mother to relevant state programs and provide them with the opportunity to enroll or obtain additional information about these programs. We are currently a finalist for this opportunity. //2014// ***//2015/ During the HHIC last summer, ISDH was one of three finalists chosen by the Indianapolis Chamber of Commerce out of more than 200 proposals to be showcased. ISDH received several proposals for the development of our two-way pregnancy application and after careful consideration, we decided to move forward and pilot the application proposed by CreateIT. The HHIC Advisory Board ended up selecting CreateIT's pregnancy application as the top innovation award winner for 2013. The application is currently being piloted with Raphael Health Center, a Federally-Qualified Health Center in Indianapolis with the goal of state-wide adoption after the pilot phase. //2015//***

Concerns involving children and adolescents center around lead poisoning, STDs, obesity, and social-emotional health of very young children. These priorities are related to State Performance Measures (SPM) 5, 8, 9, and 10, along with National Performance Measures (NPM) 7, 14 and 16. Indiana is increasing the capacity to improve these priorities. Indiana will continue to work with Medicaid, and the Lead and Immunization Programs to improve children's health. The State is also increasing capacity by funding new positions that focus on youth risks, which include STD's, physical activity, and weight and nutrition. Indiana will increase capacity over the next 5 years to improve social-emotional health for children.

Although the number of confirmed cases of lead poisoning in children (below age 72 months) has declined, lead poisoning remains a silent menace that can cause irreversible damage. MCH will continue to work with Medicaid to increase the number of children screened and to work with the Indiana Lead and Healthy Homes Program (ILHHP) to increase the number of homes remediated.

Reduction in the number of sexually transmitted diseases (STDs) is another state objective. Strategies to reduce the STD numbers include providing education and materials to providers treating adolescents, conducting a needs assessment to determine barriers to condom use among adolescents in high-risk populations, and partnering with the Indiana Family Health Council to increase screening for sexually transmitted infections.

Obesity in high school age children is also a state concern. Recent data indicate that 13.8% of youth to have a BMI greater than the 95th percentile for their age and sex. MCH will be partnering with the Division of Nutrition and Physical Activity in the deployment of the Indiana Healthy Weight Initiative that targets increased consumption of fruits and vegetables, decreased consumption of sugar-sweetened drinks and increased physical activity.

Addressing issues pertaining to the social-emotional health of children under the age of 5 is the final initiative. Foremost among these issues is the lack of qualified service providers to treat children in this age bracket. Children at risk for social, emotional, and behavioral problems include cases of neglect, homeless children, children of refugees/immigrants, and children of deployed military personnel. The proposed state initiative targets capacity building to increase the number of service providers qualified in this area.

## **C. National Performance Measures**

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

## Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	98	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100	
Numerator	184	190	207		
Denominator	184	190	207		
Data Source	ISDH - NBS	ISDH- NBS	ISDH- NBS	ISDH-NBS	ISDH-NBS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	100	100	100	100	100

### Notes - 2013

2013 Data is based on trend analysis.

ISDH-NBS

### Notes - 2012

2012 Based on trend analysis

ISDH-NBS

### Notes - 2011

Data is final.

### a. Last Year's Accomplishments

100% of infants with abnormal or presumptive positive NBS results for metabolic and endocrine conditions received follow-up until results were completed and all babies with abnormal NBS results were receiving appropriate treatment.

Effective January 2012, all birthing facilities in Indiana were required to perform pulse oximetry screening on all newborns to detect critical congenital heart defects. Of the newborns screened in 2013, 46 did not pass their pulse oximetry screen and 9 of the newborns who did not pass their pulse oximetry screen were reported to the Indiana Births Defects and Problems Registry with any heart defect. NBS developed the INSTEP application to include the results of pulse oximetry screening to allow newborn screening program staff to follow-up on babies who did not receive a pulse oximetry screen.

100% of infants with one or two gene changes for cystic fibrosis were followed-up on by the Genomics and Cystic Fibrosis Director.

All infants with confirmed positive results for an endocrine disorder, metabolic disorder, hemoglobinopathy or sickle cell disease were referred to the appropriate facilities: the Biochemical & Medical Genetics clinic at Riley Hospital for Children at Indiana University Health, the Community Health Center in Northern Indiana; the Pediatric Endocrinology clinic at Riley Hospital for Children at Indiana University Health; the Indiana Hemophilia and Thrombosis Center

(IHTC); First Steps; and/or the Children's Special Health Care Services programs.

NBS trained remaining and new birthing facility personnel and state-contracted NBS follow-up care providers to utilize INSTEP to submit monthly statistics and long-term follow-up information for children with confirmed newborn screening conditions, as needed.

NBS provided trainings to Public Health Nurses as needed and was able to contact and train additional midwives on the importance of newborn screening and how to use the INSTEP application for tracking purposes.

NBS collaborated with the Indiana Hemophilia and Thrombosis Center to collect long-term follow-up information via INSTEP for children confirmed to have sickle cell anemia.

The NBS Director continued to participate in the Region IV Genetics Collaborative, the newborn screening subcommittee of the Indiana Genetics Advisory Committee, and as a member of the Follow-up and Treatment subcommittee of the Discretionary Advisory Committee on Heritable Disorders.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. NBS is continuing to follow-up on all invalid, abnormal, and positive test results until the results are complete and negative or the babies are receiving treatment.			X	
2. NBS is continuing to refer infants with confirmed positive results to state-contracted Genetics, Endocrinology, and/or Metabolic Clinics; IHTC; Cystic Fibrosis clinics; First Steps; and the Children's Special Health Care Services programs.		X		
3. NBS is continuing to provide trainings to Public Health Nurses, hospitals, midwives, and birthing centers. Public Health Nurses and hospital staff have the option of completing these trainings in person or online.				X
4. NBS is working with the Indiana Hemophilia and Thrombosis Center to collect long-term follow-up information, via INSTEP, on children confirmed to have sickle cell anemia.			X	
5. The NBS Director is continuing to participate in the Region IV Genetics Collaborative, screening subcommittee of the Indiana Genetics Advisory Committee, and as a member of the Follow-up and Treatment subcommittee of the SACHD.				X
6. NBS is working to establish connections between birthing facilities and the ISDH data system, through a contracted entity, to allow for electronic transmission of birth notification, hearing screening results and pulse oximetry screening results.			X	
7.				
8.				
9.				
10.				

**b. Current Activities**

NBS continues to follow-up on all invalid, abnormal, and positive screening results until results are complete and negative or the babies are receiving treatment.

NBS began to establish, through OZ systems, individual connections between Indiana's birthing

facilities and the Indiana State Department of Health so that data related to critical congenital heart disease (CCHD) screening, hearing screening, and birth notification are electronically transmitted to ISDH.

NBS continues to refer infants with confirmed positive results to state-contracted Genetics, Endocrinology, and/or Metabolic Clinics; Indiana Hemophilia and Thrombosis Center (IHTC); Cystic Fibrosis clinics; First Steps; and the Children's Special Health Care Services (CSHCS) programs.

NBS continues to provide trainings to Public Health Nurses, hospitals, midwives, and birthing centers. Training topics include how to correctly conduct newborn screens and how to report invalid or abnormal screens to the Indiana State Department of Health.

NBS has linked pulse oximetry screening results to the Birth Defects and Problems Registry in order to confirm or invalidate CCHD diagnoses for infants who did not pass their screening.

The Newborn Screening Director continued to participate in the Region IV Genetics Collaborative and the newborn screening subcommittee of the Indiana Genetics Advisory Committee. The Director of MCH had direct involvement as a member of the Follow-up and Treatment subcommittee of the DACHDNC.

### **c. Plan for the Coming Year**

Continue to follow up on all invalid, abnormal, and positive screening results until results are complete and negative or the babies are receiving treatment.

Through the support of the state-contracted entity Oz Systems, NBS will continue to work to establish and maintain individual connections between Indiana's birthing facilities and the Indiana State Department of Health's data system so that data related to critical congenital heart disease (CCHD) screening, hearing screening, and birth notification are electronically transmitted to ISDH. Birth notifications are directly transmitted from a facility's electronic health records while data related to CCHD and hearing screening are transmitted directly from screening devices to INSTEP. The electronic transmission of such data provides NBS with timely newborn demographic and screening information and is made available for use by EHDI and NBS program staff within applications used for follow-up such as EHDI Alert Response System (EARS) and Indiana Newborn Screening Tracking and Education Program (INSTEP) to confirm hearing screening or pulse oximetry screening results.

Continue to explore methods to conduct long-term follow-up on children confirmed to have cystic fibrosis and critical congenital heart defects.

NBS will continue to refer infants with confirmed positive results to state-contracted Genetics, Endocrinology, and/or Metabolic Clinics; Indiana Hemophilia and Thrombosis Center (IHTC); Cystic Fibrosis clinics; First Steps; and the Children's Special Health Care Services (CSHCS) programs.

NBS will continue to provide trainings to members of the healthcare community who are involved in newborn screening such as birth hospitals, midwives, birth centers, Public Health Nurses. Trainings will continue to include education on newborn screening protocols and the use of the INSTEP and EARS applications for reporting and tracking purposes.

The Newborn Screening Director will continue to participate in the Region IV Genetics Collaborative and the newborn screening subcommittee of the Indiana Genetics Advisory Committee. The NBS Director will continue to be engaged in webinars by the Discretionary Advisory Committee on Heritable Disorders (DACHDNC). Information and recommendations from all of the above named committees will continue to be used to make informed decisions regarding

Indiana newborn screening protocols.

### Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

<b>Total Births by Occurrence:</b>	85152					
<b>Reporting Year:</b>	2012					
<b>Type of Screening Tests:</b>	<b>(A) Receiving at least one Screen (1)</b>		<b>(B) No. of Presumptive Positive Screens</b>	<b>(C) No. Confirmed Cases (2)</b>	<b>(D) Needing Treatment that Received Treatment (3)</b>	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	83710	98.3	4	4	4	100.0
Congenital Hypothyroidism (Classical)	83710	98.3	47	39	39	100.0
Galactosemia (Classical)	83710	98.3	56	3	3	100.0
Sickle Cell Disease	83710	98.3	27	27	27	100.0
Biotinidase Deficiency	83710	98.3	25	4	4	100.0
Cystic Fibrosis	83710	98.3	282	32	32	100.0
Maple Syrup Urine Disease	83710	98.3	2	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	83710	98.3	6	3	3	100.0
Glutaric Acidemia Type I	83710	98.3	1	1	1	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	83710	98.3	11	7	7	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	83710	98.3	9	8	8	100.0

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	60	59.3	60	73	73
Annual Indicator	59.3	59.3	72.6	72.6	72.6
Numerator					
Denominator					
Data Source	SLAITS	SLAITS	SLAITS	SLAITS	SLAITS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	74	74	75	75	75

#### **Notes - 2013**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **Notes - 2012**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**a. Last Year's Accomplishments**

CSHCS developed and implemented a CSHCS Family Advisory Council to ensure a family-centered perspective is maintained in all planning processes within the division that impacts CYSHCN statewide. The council consists of 15 parents of CYSHCN from around the state. The council fosters a two-pronged approach for family participation. The first is to collaborate with the CSHCS Division to ensure the parent perspective is incorporated into program planning, quality improvement, and policy and procedures processes within the division. The second is to develop their personal leadership skills through training sessions in order to become comfortable and competent in discussing the needs of CYSHCN overall, not just for their own child/children, and with a goal of serving as a model of family leadership and advocacy statewide.

Indiana selected a new Title V Family Delegate, Susan Elsworth. She is a parent of children with fetal alcohol spectrum disorders (FASD). She has been integral in the planning of the CSHCS Family Advisory Council and review the efforts within Title V around FASD.

The CSHCS Division continued its grant funding to About Special Kids (ASK), a parent-to-parent organization that supports CYSHCN and their families by providing trainings, information, peer support, education, and partnerships building with professionals and communities. ASK maintains an online resource directory and publishes an e-newsletter. They also hosted a number of webinars and in-person trainings statewide. All ASK employees are parents that have children with special needs.

The CSHCS Division continued to fund a new project for Family Voices Indiana that focused on building new family leaders through web-based training modules. The project also employed Family Leadership Specialists (all parents of children with special needs) that were contracted in different regions of the state to provide direct leadership development support and mentorship to Indiana families raising CYSHCN. The project also reached thousands of families via social media and the Family Voices Indiana blog, website, and newsletter.

The IN CISS Project sustained its efforts through the adoption of a child health improvement model, CHIP IN for Quality. The Executive Director/Pediatric Practice Consultant and Pediatric Practice Specialist for CHIP IN both have children with special needs. They both parent continue to promote and enhance parent/professional partnerships statewide.

The CSHCS Care Coordination Section continues to support all IN families of CYSHCN by having in-depth discussions to help guide families through the systems of care and assist in identifying the needs and resources available to meet their health care needs. The CSHCS Medical Eligibility Section assists families with linkages to Medical Homes and works with the CSHCS Care Coordination staff to address areas of opportunity to promote and enhance parent/professional partnerships.

The CSHCS Care Coordination Section continues to employ a care coordinator that is a parent of a child with special needs.

CSHCS continues to use a portion of its Title V funds to support projects that utilize care coordination, provide family support, and builds family leaders.

CSHCS continues to participate on disability, all children, and CYSHCN specific boards and councils that incorporate the family leader perspective at the state level.

CSHCS developed a strategic plan through the "Ease of Use of Services for Latino Families Who Have CYSHCN" Action Learning Collaborative (ALC) that incorporated the family perspective on how to make services to ease and resources more available to this population. The parent volunteers that attended the ALC meetings were integral to information gathering and the creation of the strategic plan. Parent volunteers helped gather survey information regarding barriers to



getting services for the Latino population and also participated in Latino specific celebrations and fairs.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHIP IN for Quality continues to work on improving access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN).				X
2. The IN Title V Family Delegate has formed a chapter of the National Organization on Fetal Alcohol Syndrome (NOFAS), Central Indiana NOFAS, Inc., and has been legally incorporated and is seeking non-profit status.				X
3. The Indiana Ease of Use of Services ALC will use bilingual parent staff of CYSHCN conduct trainings on resources, services, and other health related topics in Spanish for Latino Families who have CYSHCN.			X	
4. CSHCS will be collaborating with MCH to explore opportunities for expansion for the CSHCS Family Advisory Council to include other Title V populations we serve in Indiana, not just CYSHCN.				X
5. CSHCS continues to employee a parent of a child with special needs to ensure the parent perspective is incorporated into division activities around care coordination.				X
6. CSHCS parent care coordinator of a child with ASD will provide follow-up services to all children ages 0-8 years with ASD reported in the IN Birth Defects and Problems Registry.		X		
7. CSHCS continues to fund ASK, ASI, and Family Voices Indiana, all of which employees parents of CYSHCN, to assist families of CYSHCN statewide in navigating the health care systems and finding the resources that they need.		X		
8. CSHCS continues to participate on disability, all children, and CYSHCN specific boards and councils that incorporate the family leader perspective at the state level.				X
9. CSHCS and MCH will ensure the parent perspective is incorporated in the Five Year Needs Assessment and MCH Transformation 3.0.				X
10. The CSHCS Program collaborated with families of CYSHCN to bring the family perspective to the table in work on policy, procedures, and care coordination processes through the IN Title V Family Delegate and CSHCS Family Advisory Council.				X

**b. Current Activities**

The CSHCS Family Advisory Council parent consultants will continue to assist the CSHCS Division by bringing the parent perspective to the table in work on policy, procedures, and care coordination processes and meet on a quarterly basis.

The Title V Family Delegate continues to assist with the planning of the CSHCS Family Advisory Council and to build her own leadership and advocacy skills.

CSHCS continues to participate on disability, all children, and CYSHCN specific boards and councils that incorporate the family leader perspective at the state and community level.

CSHCS continues to use a portion of its Title V funds to support programs and projects that utilize care coordination, provide family support, and build new family leaders. Autism Society of Indiana is a new Title V grantee that receives funds to assist families who have children with autism spectrum disorder (ASD) find the resources and sources that they need. Funding is also still being provided to ASK and Family Voices Indiana. Like ASK and Family Voices Indiana, all staff for ASI are parents who children with ASD.

The ALC is in the process of developing trainings to inform Latino families who have CYSHCN about the resources and services available statewide as well as to educate them on health related topics. These trainings will be taught by bilingual staff of the family and parent organizations along with ALC partners.

### **c. Plan for the Coming Year**

CSHCS will continue to improve access to quality, comprehensive, coordinated community-based systems of services for CYSHCN through implementing the goals and objectives from the strategic plan that was developed for the Ease of Use of Services for Latino Families Who Have CYSHCN grant. The core group will maintain a parent partner in all decision-making processes.

The CSHCS Care Coordination Section will continue to support all Indiana families of CYSHCN by having in-depth discussions with IN families to help guide them through the systems of care and work with the child's family and doctors to identify needs and the resources available to meet their health care needs. The CSHCN Medical Eligibility Section will continue to assist families in their linkages to Medical Homes and will work with the CSHCS Care Coordination staff to address areas of opportunity to promote and enhance parent/professional partnerships.

The CSHCS Family Advisory Council will continue to meet on a quarterly basis.

CSHCS will be collaborating with MCH to explore opportunities for expansion for the CSHCS Family Advisory Council to include other Title V populations we serve in Indiana, not just CYSHCN.

The CSHCS parent care coordinator that has a child with ASD will continue conducting follow-up to families that have children ages 0-8 in Indiana diagnosed with ASD and reported to the Indiana Birth Defects and Problems Registry. This is a joint effort between CSHCS and MCH. The CSHCS parent care coordinator is involved in the resource gathering and script that will be discussed with families via telephone. She will also be important in similar processes as we expand follow-up to include additional conditions.

As CSHCS and MCH have to conduct its Five Year Needs Assessment and make changes to align with the MCH Transformation 3.0, we will ensure the parent perspective is a part of these processes.

The Title V Family Delegate will continue to assist with FASD efforts at the state level. She has formed a chapter of the National Organization on Fetal Alcohol Syndrome (NOFAS), Central Indiana NOFAS, Inc, and has been legally incorporated and is seeking non-profit status. The 501(c)(3) paperwork is being processed by the IRS and the affiliate application has been filed with NOFAS per their instructions. Becoming an affiliate of NOFAS will allow her to utilize the NOFAS name in her work

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

## Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	55	54.6	55	50	52
Annual Indicator	54.6	54.6	48.5	48.5	48.5
Numerator					
Denominator					
Data Source	SLAITS	SLAITS	SLAITS	SLAITS	SLAITS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	54	56	58	58	58

### Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

### Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

### Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two

surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **a. Last Year's Accomplishments**

The IN CISS grant was successfully closed.

The IN CISS Project continued to provide TA to the 18 Medical Home Learning Collaborative (MHLC) practices participating in Quality Improvement activities that assisted the practices transformation to family-centered, community--based, and culturally competent Medical Homes during the no-cost extension period.

About Special Kids (ASK) continued to interact with pediatric residents on a monthly basis who are being trained at the Indiana University School of Medicine on information about community resources and the Medical Home Concept and the importance of sharing this information with families who they will be seeing in practice.

The CSHCS Division continued to keep the CSHCS website updated to include information on the Medical Home Concept and how the concept was being implemented in Indiana through the MHLC.

The CSHCN Division continued to provide Title V funding to projects that promote the Medical Home Concept and link CYSHCN and their families to a primary care provider (PCP) in the clinical and parent-to-parent settings. Title V projects also disseminated the Medical Home brochures.

The CSHCS Care Coordinators and CSHCS Medical Eligibility Sections continued to link CSHCS participants and all CYSHCN statewide to a PCP, provided the families with "tools" to help them prepare for medical visits, and educated CYSHCN and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.

CHIP IN for Quality met with partners to work on statewide plan to improve access to quality, comprehensive, coordinated community-based systems of services through primary care medical homes for CYSHCN and their families that are family-centered, community-based and culturally competent. The top priority identified was Medical Home.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCS continues to promote quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families that are family-centered, community-based and culturally competent and provided through a Medical Home.				X
2. The CSHCS Division continued to keep the CSHCS website updated to include information on the Medical Home Concept and how the concept was being implemented in Indiana through the MHLC.		X		
3. The IN CISS Project continued to provide TA to the 18 Medical Home Learning Collaboratives (MHLCs) participating in QI activities to transform to family-centered, community-based, and culturally competent Medical Homes.				X

4. The CSHCS Program continues to distribute Medical Home Brochures for parents regarding Medical Home via direct mailings.		X		
5. ASK continues to connect on a monthly basis with pediatric residents who are being trained at Indiana University regarding community resources, the Medical Home Concept, and the importance of sharing this information with families.				X
6. CHIP IN for Quality will continue to identify projects that promote the Medical Home Concept at the core of implementation.				X
7. The CSHCS Division continues to provide Title V funding to projects that promote the Medical Home Concept and link CYSHCN and their families to a PCP in the clinical and parent-to-parent settings.				X
8. CHIP IN for Quality met with partners to work on statewide plan to improve access to quality, comprehensive, coordinated community-based systems of services through primary care medical homes for CYSHCN and their families.				X
9. The CSHCS Care Coordinators will continue to link CSHCS participants and all CYSHCN statewide to a PCP, educate them on the Medical Home Concept, and provide the families with resources.		X		
10. The CSHCS Program Medical Eligibility Section will continue to link CSHCS participants to a PCP provider.		X		

#### **b. Current Activities**

ASK continues to connect with pediatric residents on a monthly basis who are being trained at Indiana University on information about community resources and the Medical Home Concept and the importance of sharing this information with families who they will be seeing in practice.

The CSHCS Care Coordinators continue to link CSHCS participants and all CYSHCN statewide to a PCP, provide the families with "Tools" to help them prepare for medical visits, and educate them on the Medical Home Concept.

The CSHCS Division continues to provide Title V funding to projects that promote the Medical Home Concept and link CYSHCN and their families to a PCP in the clinical and parent-to-parent settings.

The CSHCS Division continues to distribute the Medical Home Pediatric and Young Adults brochures to new participants on the CSHCS Program that were created by CHIP IN for Quality through the IN CISS Project.

#### **c. Plan for the Coming Year**

ASK will continue connecting with pediatric residents on a monthly basis who are being trained at Indiana University on information about community resources and the Medical Home Concept and the importance of sharing this information with families who they will be seeing in practice.

The CSHCS Care Coordinators will continue to link CSHCS participants and all CYSHCN statewide to a PCP, educate them on the Medical Home Concept, and provide the families with "Tools" to help them prepare for medical visits, including the use of the Medical Home brochures.

The CSHCS Program Medical Eligibility Section will continue to link CSHCS participants to a PCP provider.

The CSHCS Division will continue to provide Title V funding to projects that promote the Medical Home Concept and link CYSHCN and their families to a PCP in the clinical and parent-to-parent settings.

CHIP IN for Quality will continue to identify projects that promote the Medical Home Concept statewide.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	62	61.8	62	62	63
Annual Indicator	61.8	61.8	58.6	58.6	58.6
Numerator					
Denominator					
Data Source	SLAITS	SLAITS	SLAITS	SLAITS	SLAITS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	63	64	64	64	64

#### Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **a. Last Year's Accomplishments**

The CSHCS Program continued to offer a supplemental coverage program for help families of children who have serious, chronic medical conditions, age birth-21 years, who meet the program's financial and medical criteria.

CSHCS Program continued to oversee and update the electronic COB process for medical claims which allows medical claims to be processed more efficiently. CSHCS continues to review and follow-up on system reports created to identify coordination and benefit issues.

Based on information in the program's Agency Claims and Administrative Processing System (ACAPS), of participants in Indiana's CSHCS program who have either private or public health insurance, approximately 89% of participants have some kind of private or public health insurance.

The CSHCS Eligibility Manager generates a quarterly Medicaid report that identifies those CSHCS participants that currently do not have Medicaid, but the system states that they would qualify. These participants are given 21 days to apply for Medicaid and show proof of their approval or denial.

CSHCS continued to track insurance and Medicaid utilization in ACAPS. This activity allowed for denial of claims for which other insurance or Medicaid coverage is available.

The CSHCS Program continues to be a "Registered Agency" with the Division of Family Resources (DFR) to allow access to their Web Portal to verify participants Medicaid/HHW status on a real-time basis.

CSHCS continued to monitor the activities and progress of the Affordable Care Act (ACA) and the impacts it would have on the CYSHCN population and also how the state would respond to the new law in the creation of a Health Care Exchange.

CSHCS Program continued to provide financial support for a satellite CSHCS office at the Riley Children's Hospital. During FY 2013, the satellite CSHCS office at Riley Hospital performed the following services for CYSHCN and their families:

- Completed 628 CSHCS applications and re-evaluations.
- Generated 4,810 Prior Authorizations.
- Completed 683 Travel vouchers.
- Obtained 9,387 additional requests for medical information for the CSHCS program.
- Conducted 1,326 outreach efforts within Riley Hospital.
- Provided 6,790 CSHCS Program informational responses to families and providers of Riley Hospital.
- Referred 890 families to support organizations/agencies to facilitate needed services for CYSHCN and their families.

CSHCS provided funding to its Title V projects for the purpose of having them speak with families about a variety of health insurance and other coverage options (such as private, public, Medicaid Waivers, Children's Special Health Care Services, SSI, etc.) and help families navigate through these sometimes complex systems. Many projects distributed the MCH Sunny Start Financial Fact Sheets on a number of coverage options. These fact sheets give families a description of

the program, eligibility criteria, and information on how to apply.

About Special Kids (ASK) continued to offer trainings to families and professionals that outline the various public health insurance programs. Follow-up with an ASK Parent Liaison helped families determine which of these programs will serve their children the best.

Family Voices Indiana continued to serve as Indiana's Family-to-Family Health Information and Education Center (F2FHIC) and educated families on numerous CYSHCN topics, including health care financing. The group's "Understanding the Funding Maze" training is frequently requested training. The presentation covers a variety of public and private coverage options. It also helps families to "think outside the box" when looking for equipment for their children. For example, utilizing Craiglists or Ebay may be a way for families to obtain used durable medical equipment.

CSHCS Care Coordinators continued to discuss with CYSHCN and their families health care financing options through CSHCS and other state programs. The CSHCS Program continues sending all participants 17-20 years of age resource letters that include information related to their insurance options as they age off of the CSHCS Program.

Effective July 1, 2013, the CSHCS Program began recognizing the new DSM-V diagnosis criteria for the autism spectrum disorder (ASD) which expanded the program's definition of autism and who would qualify for the program. The program continues to enroll twice as many individuals each month under the Autism diagnosis, half of whom would not have previously qualified.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCS Program oversees and updates the electronic COB process for medical claims which allows medical claims to be processed more efficiently.				X
2. CSHCS Program provides financial support for a satellite CSHCS office at Riley Children's Hospital. The Riley CSHCS office will continue to support CYSHCN and their families.		X		
3. CSHCN Division provides funding to its Title V projects for the purpose of having them speak with families about a variety of health insurance options and help families navigate through these complex systems.		X		
4. ASK continued to offer trainings to families and professionals that outline the various public health insurance programs.		X		
5. Family Voices Indiana continues to serve as Indiana's Family-to-Family Health Information and Education Center (F2FHIC).		X		
6. CSHCS Program continued to send all participants age 17-20 years and up information on insurance options to apply for as they age off Hoosier Healthwise.		X		
7. 7. CSHCS continued to monitor the activities and progress of the Affordable Care Act (ACA) and the impacts it would have on the CYSHCN population and also how the state would respond to the new law in the creation of a Health Care Exchange.				X
8. The CSHCS Program continues to be a "Registered Agency" with the Division of Family Resources (DFR) to allow access to their Web Portal to verify participants Medicaid/HHW status.				X
9. The CSHCS Program has enrolled more CYSHCN diagnosed with Autism due to the DSM-V definition change.		X		



10. CSHCS is monitoring the impact that changes to Indiana Medicaid and Medicaid waivers will have on the program and the CYSHCN population.				X
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#### **b. Current Activities**

CSHCS continues to provide funding for a satellite CSHCS office at Riley Children's Hospital. Their office was moved to another location within the building.

CSHCS continues to fund ASK, Family Voices Indiana, and its other Title V projects for the purpose of having them speak with families about a variety of health insurance options and help families navigate through these complex systems.

CSHCS Care Coordinators continue to discuss with CYSHCN and their families available options for health care financing through CSHCS and other state programs. CSHCS program will continue sending all participants aged 17 years information on their insurance options as they age off Hoosier Healthwise.

CSHCS Care Coordinators and the parent and family organizations will continue to educate themselves on health care options available for CYSHCN to ensure they have access to adequate health care coverage.

CSHCS is monitoring the impact that changes to Indiana Medicaid and Medicaid waivers will have on the program and the CYSHCN population.

#### **c. Plan for the Coming Year**

The CSHCS Program will continue to oversee and update the electronic COB process for medical claims which allows medical claims to be processed more efficiently. CSHCS continues to review and follow-up on system reports created to identify coordination and benefit issues.

CSHCS Care Coordinators will continue to discuss with CYSHCN and their families health care financing options through CSHCS and other state programs. The CSHCS Program continues sending all participants 17-20 years of age resource letters that include information related to their insurance options as they age off of the CSHCS Program.

CSHCS will continue to provide funding for a satellite CSHCS office at Riley Children's Hospital. Their office was moved to another location within the building.

CSHCS will continue to fund ASK, Family Voices Indiana, and its other Title V projects for the purpose of having them speak with families about a variety of health insurance options and help families navigate through these complex systems.

CSHCS Care Coordinators will continue to discuss with CYSHCN and their families available options for health care financing through CSHCS and other state programs. CSHCS program will continue sending all participants aged 17 years information on their insurance options as they age off Hoosier Healthwise.

CSHCS Care Coordinators and the parent and family organizations will continue to educate themselves on the health care options for CYSHCN to ensure they have access to adequate health care coverage.

CSHCS will continue to monitor the impact that changes to Indiana Medicaid and Medicaid waivers will have on the program and the CYSHCN population.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	95	94.3	95	66	68
Annual Indicator	94.3	94.3	65.9	65.9	65.9
Numerator					
Denominator					
Data Source	SLAITS	SLAITS	SLAITS	SLAITS	SLAITS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	70	72	74	74	74

**Notes - 2013**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2012**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised

extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **a. Last Year's Accomplishments**

The CSHCS Division continued to improve the organization and delivery of services to children and youth with special health care needs (CYSHCN); reimburse families for in-state and out-of-state transportation of CSHCS participants to medical facilities for services; maintain and provide lists of primary care physicians (PCP) participating in the CSHCS program; use a customer service representative on an "as needed" basis to take applications in specialty care centers such as hospitals and other care facilities; communicate with the programs participants, providers and community partners via e-mail, the web portal, and the CSHCS website to provide real-time information sharing on an ongoing basis.

The CSHCS Division maintained a satellite CSHCS Program office at Riley Children's Hospital to assist families in-person to complete applications and re-evaluations, generate prior authorizations for services, complete travel vouchers, conduct CSHCS Program informational sessions to families and providers of Riley Hospital, and make referrals to support organization and agencies that serve/support CYSHCN.

The CSHCS Division Care Coordination Section continued providing in-house care coordination to CSHCS participants and all CYSHCN statewide. The Care Coordinators assessed the participants and their families' needs and made appropriate referrals to community, medical, and other identified areas. The section maintained a focus linking the participants to a PCP, provided the families with "Tools" to help them prepare for medical visits, and educated the participants and their families on the Medical Home Concept.

The CSHCS Division Care Coordination Section continued to participate in community trainings and conferences conducted by parent support organizations in order to expand their awareness of up-to-date community resources while also sharing their knowledge at community health and transition fairs that support CYSHCN.

The CSHCS Division used Title V funding to support projects that provide care coordination services that link the CYSHCN and their families to appropriate community-based resources and services.

CSHCS continued to serve on boards and councils focused on improving community-based service systems that are coordinated and easily accessible for CYSHCN and their families.

Title V maintained an 800 Family Help Line with V/TDD capabilities and bilingual support that refers families to community-based services and maintains a database of over 10,000 resources.

CHIP IN for Quality created and posted YouTube videos on statewide community-based services for families and providers of CYSHCN. These videos are also posted on the CSHCS website.

CSHCS Ease of Use Action Learning Collaborative (ALC) developed a strategic plan to address making services easier to use for Latino families with CYSHCN statewide.

CSHCN Act Early. Learn the Signs. initiative created a "Roadmap to Services" brochure for families who are concerned their child may have an autism spectrum disorder (ASD).

CSHCS Care Coordinators continue to make appropriate community-based referrals to CSHCS participants and all CYSHCN statewide that are coordinated, easily accessible, and community-

based. They also continue to participate as an exhibitor at health and transition fairs and in trainings to expand their knowledge of community-based resources.

CSHCS continues to serve on a variety of boards and councils focused on improving community-based service systems that are coordinated and easily accessible for CYSHCN and their families.

CSHCS continues to support Title V projects that provide care coordination services to ensure all CYSHCN and their families are linked to community-based resources that are coordinated and easily accessible. These projects span clinics, family and parent organizations, and population specific outreach (Amish, Spanish-speaking, and African-American communities).

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCS Care Coordinators continue to make appropriate community-based referrals to CSHCS participants and all CYSHCN statewide that are coordinated, easily accessible, and community-based.		X		
2. CSHCS continues to fund and collaborate with ASK, Family Voices Indiana, and Autism Society of Indiana to provide family-to-family and parent-to-parent peer support.		X		
3. ASK continued to update existing resources in its online directory and add new resources as they become available.			X	
4. ASK utilizes a language line to serve families that speak languages other than English, primarily Burmese-speaking, and will continue to provide follow-up to these families to ensure they are accessing the appropriate resources and services.		X		
5. The CSHCS Division continues to fund Title V projects that provide care coordination services that link the CYSHCN and their families to appropriate community-based resources and services.		X		
6. CSHCS continues to serve on boards and councils focused on improving community-based service systems that are coordinated and easily accessible for CYSHCN and their families.				X
7. CSHCS Ease of Use ALC developed a strategic plan to address making services easier to use for Latino families with CYSHCN statewide and are addressing goals and activities on the plan.				X
8. CSHCS is collaborating with MCH to conduct follow-up for all children ages 0-8 years of age diagnosed with an ASD and that are reported into the Indiana Birth Defects and Problems Registry.		X		
9. The CSHCS Division employs a care coordinator that is a parent of a child with autism. She provides the parent perspective on improving organized community-based service systems that are easy for CYSHCN and their families to access.				X
10. MCH maintains an 800 Family Help Line with V/TDD capabilities and bilingual support and refers families to community-based services.		X		

**b. Current Activities**

CSHCS continues to reimburse families for in-state and out-of-state transportation to medical facilities for services for CSHCS Program participants and continues to communicate with the programs participants, providers, and community partners via e-mail and the CSHCS website to provide real-time information sharing on an ongoing basis.

CSHCS continues to collaborate with its partners from the Ease of Use ALC and implement projects based on the developed strategic plan to address making services easier to use for Latino families with CYSHCN. The first project is piloted a Basic Spanish Training for community-based providers.

CSHCS continues to promote cultural competence in Title V work. Family Voices Indiana receives Title V funding to run a Promotora program that supports the Spanish-speaking, African-American, and Amish communities. About Special Kids (ASK), another parent organization, receives Title V funding to support a bilingual parent liaison and to operate a language line to assist the Burmese speaking and other populations.

The CSHCS Division continues to support its Title V projects that provide care coordination services to ensure all CYSHCN and their families are linked to community-based resources that are coordinated and easily accessible.

CSHCS is collaborating with MCH to conduct follow-up for all children ages 0-8 years of age diagnosed with an ASD and that are reported into the Indiana Birth Defects and Problems Registry.

### **c. Plan for the Coming Year**

The CSHCS Division will continue to address goals and activities from strategic plan for making services to use for Latino families who have CYSHCN. The next project will is to provide trainings to families, primarily in the high Latino population areas of Lake and Marion Counties. Bilingual Family Voices staff that work with both communities identified the most requested trainings. ALC members will be partnering together to create comprehensive information sharing trainings on resources and services available in the state.

The CSHCS Division will continue to partner with the MCH Division to ensure all children ages 0-8 receive follow-up after being reported to the Indiana Birth Defects and Problems Registry. This follow-up will ensure those diagnosed with ASD are receiving information about community-based resources and services as early as possible. This follow-up will be conducting by a CSHSC care coordinator that has a child with autism. CSHCS and MCH will also explore expanding this follow-up to other reported conditions.

The CSHCS Division will continue to fund CSHCS Title V grantees focused on providing care coordination to CYSHCN statewide. The number of projects focusing on care coordination has increased from six to nine projects. Three family and parent organizations are being funded: ASK, Family Voices Indiana, and Autism Society of Indiana.

The CSHCS Care Coordination Section will continue expanding its reach throughout the state to make appropriate community-based referrals to CSHCS participants, CYSHCN statewide, and their families that are coordinated, easily accessible, and community-based. The section will also continue to participate as an exhibitor at community health and transition fairs and in trainings to expand their knowledge of community-based resources.

CSHCS will continue to serve on a variety of boards and councils focused on improving community-based service systems that are coordinated and easily accessible for CYSHCN and their families.

CSHCS will continue to work with Project LAUNCH to identify the resources and services available for CYSHCN who are dually diagnosed with a chronic condition and mental health disorder.

CSHCS will work with agency and community partners to explore the creation of a comprehensive, statewide care coordination network to streamline care coordination services across the state.

CSHCS will continue to support the use of the Sunny Start fact sheets for CYSHCN. These fact sheets are brief descriptions of statewide programs and resources that can be easily accessed on the Early Childhood Meeting Place website by families.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	41.5	41.1	42	44	45
Annual Indicator	41.1	41.1	43.7	43.7	43.7
Numerator					
Denominator					
Data Source	SLAITS	SLAITS	SLAITS	SLAITS	SLAITS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	46	47	48	48	48

#### Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the

questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **a. Last Year's Accomplishments**

The CSHCS Division continued to provide financial support to the Center for Youth and Adults with Conditions of Childhood (CYACC) to provide leadership in facilitating the transition to adulthood for Indiana youth and young adults with special health care needs through Title V funding. CYACC and its partners continued to coordinate and share information and develop resources that support transition to adulthood, concentrating on targeting CYSHCN and their families as well as primary and specialty care practices. Resources were developed through collaborations between CYACC and IU School of Medicine. CYACC receives input through multiple community agencies via a community advisory board. Learners and current professionals from multiple disciplines are trained on concepts of transition, supporting community resources, and methods to implement into practice to assist Indiana's CYSHCN become more prepared for adult life.

Members from the CYACC team facilitated transition quality improvement discussions with 3 pediatric subspecialist sections to identify opportunities for improvement in transfer of care to adult specialists. Over 100 pediatric or combined-pediatric residents attended at least one clinic session to learn about transition of YSHCN, health care financing options for patients with special health care needs, and accommodated physical and mental health assessment and care for this patient population. Furthermore, medical and social work students participated in service learning projects facilitated by the CYACC program aimed at improving health outcomes through partnership with the Arc of Indiana and Best Buddies of Indiana.

CYACC team continued to develop Individualized Health Assessment Plans (IHAPs) for all new patients seen in clinic and mailed to primary care providers. In FY 2013, the CYACC team evaluated 282 patients: 145 new patients and 137 return patients. Of the 282 total patients seen, 201 patients received mental health screening.

CYACC continued including parents of CYSHCN on the CYACC Advisory Board to provide their perspective on transition issues.

CSHCS continued to participate on the CYACC Advisory Board to work on interagency initiatives with CYACC regarding transition for individuals with disabilities from school to work or youth to adult health services.

Drs. Mary Ciccarelli and Jason Woodward, with Elise Montoya conducted a 3-hour skills-building session at the AMCHP Conference in Washington, D.C. guiding participants through creation and development of transition plan for three mock patients; one for each diagnosis category of physical, intellectual, and chronic condition.

More than 500 printed copies of the Indiana Transition Workbook have been distributed to patients, providers, and community agencies through conferences, info fairs, clinical visits, and the children's hospital library. Four states (WI, NC, NV, and IA) have expressed interest in adapting state-specific information and utilizing the workbook in their respective regions.

Riley Hospital for Children, as the state's only comprehensive children's hospital, has long served children with neurodevelopmental and behavioral disorders as both inpatients and outpatients. Recognizing the need for more coordinated services, Riley established the Neurodevelopmental and Behavioral Center (NDBC) to focus on the local community and allows rapid access for diagnosis and early management. CYACC has been instrumental in helping to establish this center. Dr. Ciccarelli devotes a portion of her time to assist with the screening and diagnosis of children that come to the center. The current focus is on Autism Spectrum Disorder (ASD). The current average age of diagnosis in Indiana for ASD is over 5 years of age whereas the average age of diagnosis in the NDBC is 30 months. CYACC hopes their role in the development of the NDBC will prepare children impacted by this program for transition at a very early age; leading to better long-term health outcomes and preventing transition-age crises for Indiana's youth with neurodevelopmental and behavioral disorders.

CSHCS Title V grantees continued to collaborate with CYACC to ensure the CYSHCN at transition age were receiving consistent information related to transition.

CSHCS Care Coordinators participated in joint in-service learning opportunities with parent and family organizations to receive ongoing training and updates on numerous topics for CYSHCN, including transition to adulthood for CYSHCN.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCS continues to distribute the Transition Manual to 100% of the CSHCS program participants aged 11-21 years.		X		
2. CSHCS and CYACC continues to participate in transition and medical health fairs as an exhibitor.			X	
3. CSHCS staff continues to receive ongoing training and updates regarding transitioning CYSHCN to adult health care, work, and independence through trainings and informational materials.				X
4. CSHCS continues to provide financial support to the Center for Youth and Adults with Conditions of Childhood (CYACC). The center's focus is on transitional health care for youth with special health care needs.				X
5. CYACC continues to work with health care providers statewide on transitioning youth with special health care needs to adult care.				X
6. The state Transition Workbook continues to be distributed statewide and also adapted by other states.		X		
7. CYACC continues to convene their Youth Advisory Board, comprised of youth and young adults with a number of chronic conditions and diverse backgrounds, quarterly to provide consumer perspective on transition issues.				X



8. CSHCS continues to provide transition materials and resources to IN CYSHCN and their families to meet their transitional needs in all aspects of life.		X		
9. CYACC continues to expand its resident learner training and curriculum to medical students and residents and also continue to educate interns from multiple academic disciplines (social work, public health, and nursing).			X	
10. CSHCS continues to work on interagency initiatives regarding transition for individuals with disabilities from school to work or youth to adult health services via the CYACC Advisory Board.				X

#### **b. Current Activities**

CSHCS continues to provide financial support to the CYACC Transition Clinic so the clinic can provide transitions services, support and materials to CYSHCN, families, and providers throughout the state.

CSHCS Care Coordinators continue to have in-depth discussions with IN families regarding transition to adult health care and providing resources that meet their transition needs, including the new state Transition Workbook.

CSHCS and CYACC continue to participate in transition and medical health fairs as exhibitors.

CSHCS continues to work with the CYACC Advisory Board to address transition related issues.

CYACC continues to execute the "Be Your Own Boss" workshops and work with Down Syndrome Indiana (DSI) self-advocates on the "Welcome to Adult Life" curriculum in order to education youth and young adults on transition and self-management.

CYACC continues to research and identify various methods of mental health screening for patients with varying cognitive and developmental abilities to better document mental health status.

CYACC continues to expand its resident learner training and curriculum to medical students and residents and also continue to educate interns from multiple academic disciplines (social work, public health, and nursing).

Transition continues to be a high priority top discussed by the CSHCS Family Advisory Council.

CYACC will continue to devote time and effort to the continued development and success of the NDBC.

#### **c. Plan for the Coming Year**

CSHCS will continue to provide financial support to CYACC through the Indiana University School of Medicine, Department of Pediatrics to continue providing transitions services, support and materials to CYSHCN, families, and providers throughout the state.

The CSHCS Care Coordination Section will continue to have in-depth discussions with Indiana families regarding transition to adult health care and providing resources that meet their transition needs.

CSHCS and CYACC will continue to participate in transition and medical health fairs as an exhibitor.

CSHCS staff will continue to receive ongoing training and updates regarding transitioning CYSHCN to adult health care, work, and independence.

CSHCS will continue to work with the CYACC Advisory Board to address transition related issues.

CYACC will continue to execute the "Be Your Own Boss" workshops over the next year and continue work with Down Syndrome Indiana self-advocates on the "Welcome to Adult Life" curriculum in order to education youth and young adults on transition and self-management.

CYACC will continue to explore options for creating an interactive online environment for the Transition Workbook.

CYACC will continue identifying various methods of mental health screening for patients with varying cognitive and developmental abilities, allowing them to better document mental health status.

CYACC will continue to educate interns from multiple academic disciplines (social work, public health, and nursing).

CSHCS will ensure the Family Advisory Council's questions and concerns related to transition to adulthood are addressed and they receive the information they need to be informed themselves and then to properly assist other families in their communities.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	85	89.5	90.5	90.5	91
Annual Indicator	89.1	90.5	90.5	91	91
Numerator					
Denominator					
Data Source	ISDH - Imm. Pgm	ISDH - Imm Pgm	ISDH - Imm Pgm	ISDH - Imm Pgm	ISDH - Imm Pgm
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	91.5	92	92	92	92

#### Notes - 2013

2013 Based on trend analysis

**Notes - 2012**

2012 Based on trend analysis

**Notes - 2011**

Data based on trend analysis.

**a. Last Year's Accomplishments**

The Immunization Division conducted Vaccines for Children (VFC) and AFIX visits at VFC-enrolled MCH sites to assess implementation of VFC policies.

The Immunization Division focused on proper storage and handling capacity in the state of Indiana pursuant to the Storage and Handling Toolkit published by the Centers for Disease Control and Prevention (CDC). This intensified effort was to ensure that vaccine was stored properly and at recommended temperatures to guarantee the viability of the vaccine. Worked with all 900+ providers to discontinue "dorm" style refrigerators and install temperature monitoring devices on approved storage units.

The Immunization Division conducted a county assessment of each county on their compliance with the CDC ACIP (Advisory Committee on Immunization Practices) recommended 4:3:1:3:3:1:4 series. Each county was told what their rate and given individualized action steps to increase compliance by focusing on antigen specific vaccines that were below the state average.

The Immunization Division conducted three reminder recall in 2013. The reminder recalls were based on data extrapolated from the county assessments and/or new vaccine recommendations. The three reminder recalls focused on:

- The fourth dose of DTaP -- designed to reach the children that were missing the fourth dose of DTaP due to proper vaccine intervals.
- The second and third dose of HPV -- designed to reach those individuals that had started the HPV series but had not received the second or third dose.
- MCV4 booster dose -- designed to reach individuals that might not be properly protected from meningitis disease.

The Immunization Division completed a survey and audit of each of the 96 birthing hospitals in Indiana to evaluate their current written policies and procedures regarding prevention of perinatal hepatitis B infection. According to the 2012 National Immunization Survey (NIS), Indiana is first in the nation for Hepatitis B birth dose coverage with 83.4% of all babies the vaccine within suggested timeframes.

The Immunization Division worked with the Indiana Immunization Coalition to conduct three (3) billing workshops. The aim of these workshops was to increase the capacity of local health departments to bill for services provided in good faith for individuals with third party insurance coverage. As a result, 59% of local health departments have or are in the process of developing the capacity to bill all third party insurances for both vaccines and vaccine administration. This capacity will also enable local health departments to bill third party insurance for other covered services, such as blood lead testing, TB testing and follow-up care, STI/HIV services, etc.

MCH worked with the Immunization Program to increase the number of sites using the Children Hoosiers Immunization Registry Program (CHIRP) reminder/recall feature.

MCH coordinated with the Immunization Program to provide educational opportunities for WIC program staff.

MCH staff attended the Indiana Immunization Coalition and participated in its activities.

MCH worked with the Immunization Program to increase the number of MCH sites enrolled as

VFC and/or CHIRP providers.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Immunization Division conducted the Vaccines for Children (VFC) and Assessment, Feedback, Incentives, eXchange (AFIX) visits at selected VFC-enrolled Maternal and Child Health (MCH) sites to assess implementation of VFC policies.			X	
2. MCH worked with the Immunization Program to increase the number of sites using the Children and Hoosiers Immunization Registry (CHIRP) reminder/recall feature.				X
3. MCH coordinated with the Immunization Program to provide educational opportunities for WIC program staff.			X	
4. MCH staff attended the Indiana Immunization Coalition meetings and participate in its activities.				X
5. MCH worked with the Immunization Program to increase the number of MCH sites enrolled as VFC and/or CHIRP providers.				X
6. The Immunization Division increased storage and handling compliance to ensure viable vaccine.				X
7. The Immunization Division worked with healthcare providers to submit complete data to the Indiana Immunization Information System (IIS), CHIRP.				X
8.				
9.				
10.				

**b. Current Activities**

The Immunization Program conducts VFC and AFIX visits at all VFC-enrolled MCH sites to assess implementation of VFC policies.

MCH works with the Immunization Program to increase the number of sites entering data into CHIRP, whether manually or electronically through interfaces.

MCH works with the Immunization Program to increase the number of MCH sites enrolled as VFC and/or CHIRP providers.

MCH coordinates with the Immunization Program to provide educational opportunities for WIC program staff.

MCH staff attends the Indiana Immunization Coalition and participates in its activities.

The ISDH Immunization Division Director continues to implement a policy allowing Federally Qualified Health Centers (FQHCs) to delegate authority to local health departments for immunization of underinsured children under the VFC program.

MCH and the Immunization Program work with the Family and Social Services Administration to ensure the immunization status of child care attendees complies with state requirements.  
MCH and the Immunization Division work with providers to increase compliance with the ACIP recommendations by conducting reminder/recalls at the state and local level.  
MCH and the Immunization Division work with providers to increase compliance with the ACIP recommendations by conducting a county assessment and communicating the results and an

action plan to each county.

### **c. Plan for the Coming Year**

The Immunization Division will conduct VFC and AFIX visits at all VFC-enrolled MCH sites to assess implementation of VFC policies.

The Immunization Division will conduct a reminder recall initiative designed to reach those individuals between the ages of 11-21 that have not started the HPV series. There are approximately 530,000 individuals in this co-hort that the Immunization Division will attempt to reach in an effort to decrease the incidence of HPV and subsequent related cancers.

MCH will work with the Immunization Division to increase the number of sites using the Children Hoosiers Immunization Registry Program (CHIRP) reminder/recall feature.

MCH will coordinate with the Immunization Division to provide educational opportunities for WIC program staff.

MCH staff will attend the Indiana Immunization Coalition and participated in its activities.

MCH will work with the Immunization Division to increase the number of MCH sites enrolled as VFC providers.

MCH will work with Immunization Division to implement the mandatory reporting of immunization to the Indiana Immunization Registry, CHIRP, as authorized by Senate Enrolled Act 415-2013.

MCH will work with the Immunization Program and the Indiana Immunization Coalition to increase awareness of the HPV vaccine in an effort to reduce cervical cancer in women.

The ISDH Immunization Division Director will affirm and/or renew the policy as needed allowing Federally Qualified Community Health Centers (FQCHCs) to delegate authority to local health departments for immunization of underinsured children under the VFC program.

MCH will assist the Immunization Program in implementing new vaccine eligibility changes in public and provider offices.

MCH will work with the Immunization Program to promote the use of MyVaxIndiana, a web-based tool that enables parents to view and print their child's immunization record.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

#### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	20	19.8	19.6	19.8	15.9
Annual Indicator	20.8	18.5	16.0	15.9	16
Numerator	2730	2481	2135	2137	
Denominator	131357	134229	133115	134067	
Data Source	ISDH - ERC	ISDH - ERC	ISDH-ERC	ISDH-ERC	ISDH-ERC
Check this box if you cannot report					

the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	15.9	15.8	15.8	15.7	15.9

#### **Notes - 2013**

2013 Data is based on trend analysis.

Source of data: ISDH - ERC

#### **Notes - 2012**

2012 Data based is provisional  
ISDH-ERC data.

#### **Notes - 2011**

2011 Data is provisional.

Source of data: ISDH - ERC

#### **a. Last Year's Accomplishments**

The State Adolescent Health Coordinator (SAHC) supervised the YRBS Coordinator to disseminate data findings from the 2011 Youth Risk Behavior Survey (YRBS) as well as assist with the administration of the 2013 YRBS survey. The Indiana State Department of Health received funding for the School Health Profiles Survey for the first time (previous administered by the Department of Education); the SAHC designed sampling frame perimeters and compiled schools for the 2014 School Health Profiles Survey (Profiles) sample.

SAHC participated on the ICIAH which has addressing risky sexual behaviors among adolescents as one of its priorities.

ICIAH created and published a handbook for teens that provides health information on a variety of topics including STIs, pregnancy and abstinence. The Indiana Coalition to Improve Adolescent Health (ICIA) was working with its statewide partners to distribute a handbook for teens (created in 2012) that provides health information on a variety of topics including STIs, pregnancy, and abstinence. ICIAH also hosted a website for teens. Teens could submit health questions that were answered by a medical professional. It was anticipated that most questions would be related to sex and reproductive health issues.

SAHC promoted the National Day to Prevent Teen Pregnancy, sponsored by the National Campaign to Prevent Teen and Unplanned Pregnancy to its grantees, community organizations, and other funded partners.

SAHC finalized the Indiana RESPECT grant application process for SFY 2013-2014 and oversaw the application and review process, including the identification of funded projects and provision of technical assistance to funded projects.

SAHC finalized the Abstinence Education Grant Program application for Federal FY 2013-2014 and oversaw the application and review process, including the identification of funded projects and provision of technical assistance to funded projects. One additional grantee, from the previous year, was adding, expanding services to more youth across the state.

SAHC served as the family planning consultant for the state and administrator of the Indiana Family Planning Partnership.

SAHC promoted the ISDH Free Pregnancy Test program to school-based clinics and community organizations.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SAHC continued supervising the YRBS Coordinator to disseminate data findings from the 2011 survey as well as assist with the administration of the 2013 YRBS survey.				X
2. SAHC continued supervising the Abstinence Education Program coordinators and their grantees.				X
3. The funding award for the Pregnant and Parenting Adolescent Support Services (PPASS) Program, with a priority of reducing teen pregnancy rates, was not re-awarded, but was extended with a no-cost extension which will run through the end of May, 2014.				X
4. After state approval, MCH conducted a media marketing campaign to ensure that teens have access to relevant, reliable, and accurate information regarding abstinence education and pregnancy prevention.		X		
5. MCH contracted with Health Care Education and Training (HCET) to develop a texting method for parents to talk to their kids about sex and abstinence				X
6. MCH continued to fund three school-based adolescent health clinics to provide services to students, including free pregnancy tests and counseling about sex and abstinence.	X			
7. SAHC continued to serve as the adolescent family planning consultant for the state and administrator of the Indiana Family Planning Partnership.				X
8.				
9.				
10.				

**b. Current Activities**

SAHC is supervising the YRBS Coordinator to disseminate data findings from the 2011 survey, as well as assisting with the administration of the 2014 School Health Profiles Survey and the 2015 Youth Risk Behavior Survey (YRBS).

SAHC is coordinating the Pregnant and Parenting Adolescent Support Services (PPASS) Program, which has a priority area of reducing subsequent pregnancies among Indiana teens, through the end of May and the close of the no-cost extension. A Final Report will be written and submitted in August 2014.

SAHC is supervising the Abstinence Education Program, where Indiana was awarded \$956,462 million to promote evidence-based abstinence education throughout the state.

SAHC is serving as the adolescent family planning consultant for the state and administrator of the Indiana Family Planning Partnership.

MCH is funding two school-based adolescent health clinics to provide services to students,

including free pregnancy tests and counseling about sex and abstinence.

SAHC is participating in the ICIAH in addressing risky sexual behaviors among adolescents as well as other issues that affect teen health.

MCH is contracting with the Center of Excellence in Women's Health at Indiana University to send a Wellness on Wheels (WOW) bus to rural Indiana to provide free pregnancy tests and counseling about sex and abstinence.

MCH is contracting with Health Care Education and Training (HCET) to develop a texting method for parents to talk to their kids about sex and abstinence.

### **c. Plan for the Coming Year**

SAHC will continue supervising the YRBS Coordinator to finalize the dissemination of the 2014 Profiles survey and administration of the 2015 YRBS survey and dissemination of weighted data to constituents throughout the state.

SAHC will continue supervising the Abstinence Education Program coordinators and their grantees.

SAHC will continue serving as the adolescent family planning consultant for the state and administrator of the Indiana Family Planning Partnership.

SAHC will continue participating in the ICIAH in addressing risky sexual behaviors among adolescents as well as other issues that affect teen health.

MCH will be funding two school-based adolescent health clinics to provide services to students, including free pregnancy tests and counseling about sex and abstinence.

SAHC will oversee a contract using RESPECT funding with HCET for the continuation of the parenting texting program, IPEP, as well as BrdsNBz and iKnow.

SAHC will contract with the Center of Excellence in Women's Health at Indiana University to send a Wellness on Wheels (WOW) bus to rural Indiana to provide free pregnancy tests and counseling about sex and abstinence.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	50	50	24	24.5	23
Annual Indicator	50	50.0	24.0	24.5	23
Numerator		39710	20125	21312	
Denominator		79420	83854	86986	
Data Source	ISDH - Oral Hlth	ISDH - Oral Hlth	ISDH- Oral Hlth	ISDH-Oral HLTH	ISDH-Oral HLTH
Check this box if you cannot report the numerator because					



1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	25.5	26	26.5	26	26

#### Notes - 2013

2013 data is provisional and is estimated and based on data trends.

Source: ISDH-Oral Health and IDOE

#### Notes - 2012

2012 data is provisional and is estimated and based on data trends.

Source: ISDH-Oral Health and IDOE

#### Notes - 2011

2011 data is provisional and is estimated and based on data trends.

Source: ISDH-Oral Health and IDOE

#### a. Last Year's Accomplishments

The OHP utilized funds from the Delta Dental Foundation to conduct a surveillance project to determine the oral health status of children in local communities, including the prevalence of dental sealants.

The OHP utilized funds from the PHHS Block Grant to plan and conduct a survey of the oral health and BMI status of children, including the prevalence of dental sealants.

The OHP utilized funds from the Title V MCH Block Grant to support dental sealant programs in central and northern Indiana.

The OHP and the IU School of Dentistry utilized funds from a HRSA grant to work with a Federally Qualified Health Center (FQHC) to plan a pilot project to place dental sealants on the teeth of children in schools.

The OHP collaborated with partners such as the IU School of Dentistry, Indiana Dental Association, the Indiana Oral Health Coalition and other partners in the state to help achieve one of the OHP's major goals of preventing dental decay in children, with one preventive intervention being the use of dental sealants.

The OHP submitted and had approved an Indiana Oral Health Plan, which emphasizes primary prevention of oral diseases as a major goal, including the use of dental sealant programs.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The OHP is utilizing Title V MCH Block Grant funding to support dental sealant programs in low-income schools, a	X			

community health center and a local health department.				
2. The OHP and the Indiana University School of Dentistry are using HRSA funding to plan and conduct a pilot project to determine the feasibility of expanding school-based sealant programs in Indiana.				X
3. The OHP is collaborating with partners such as the IU School of Dentistry, Indiana Dental Association, the Indiana Oral Health Coalition and other partners in the state to promote the use of dental sealants to prevent dental decay in children.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The OHP is continuing to use funds from the Title V MCH Block Grant to support dental sealant programs in central and northern Indiana.

The OHP and the IU School of Dentistry are continuing to utilize funds from a HRSA grant to work with a Federally Qualified Health Center (FQHC) to plan and conduct a pilot project to place dental sealants on the teeth of children in schools.

The OHP is collaborating with partners such as the IU School of Dentistry, Indiana Dental Association, the Indiana Oral Health Coalition and other partners in the state to help achieve one of the OHP's major goals of preventing dental decay in children, with one preventive intervention being the use of dental sealants.

The OHP is collaborating with the Indiana Rural Health Association to investigate the possibility of submitting a grant application to the National Institutes of Health (NIH) to conduct a project to improve dental health literacy among children and their parents, including the benefits of the use of dental sealants.

The OHP has obtained surveillance data from NCDR, LLC and Kool Smiles clinics, which is being used to determine the oral health status of children in local communities in Indiana.

The OHP is working with a biostatistician at the Indiana University School of Medicine to try to develop a method of using surveillance data to provide population-based estimates of the oral health status of children in Indiana, including the prevalence of dental sealants.

#### **c. Plan for the Coming Year**

The OHP plans to continue to use funds from the Title V MCH Block Grant to support dental sealant projects in central and northern Indiana.

The OHP and the IU School of Dentistry plan to continue utilizing funds from a HRSA grant to work with a Federally Qualified Health Center (FQHC) to plan and conduct a pilot project to place dental sealants on the teeth of children in schools.

The OHP plans to continue collaborating with partners such as the IU School of Dentistry, Indiana Dental Association, the Indiana Oral Health Coalition and other partners in the state to help achieve one of the OHP's major goals of preventing dental decay in children, with one preventive

intervention being the use of dental sealants.

The OHP plans to continue collaborating with the Indiana Rural Health Association to investigate the possibility of submitting a grant application to the National Institutes of Health (NIH) to conduct a project to improve dental health literacy among children and their parents, including the benefits of the use of dental sealants.

The OHP plans to continue working with a biostatistician at the Indiana University School of Medicine to try to develop a method of using surveillance data to provide population-based estimates of the oral health status of children in Indiana, including the prevalence of dental sealants.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	2.8	3.3	3.2	1.9	1.8
Annual Indicator	2.0	2.5	2.3	2.4	
Numerator	27	33	31	32	30
Denominator	1318933	1329013	1323698	1330150	
Data Source	ISDH - ERC	ISDH - ERC	ISDH-ERC	ISDH-ERC	ISDH-ERC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	1.8	1.7	1.7	1.7	1.7

#### Notes - 2013

2013 data is based on trend analysis.

ISDH-ERC

#### Notes - 2012

2012 Data is provisional.

Source of data: ISDH - ERC

#### Notes - 2011

2011 Data is Provisional.

Source of data: ISDH - ERC

#### a. Last Year's Accomplishments

On January 14, 2013, Governor Pence re-issued Governor Daniels' original Executive Order creating the Indiana State Trauma Care Committee. The group meets quarterly.

ISDH, through the Public Health Block Grant, funded a full-time injury prevention epidemiologist for the ISDH Injury Prevention Program until her resignation in May, 2011. A new full-time injury prevention epidemiologist started June 2013 and has been with the division since. ISDH provides meeting space for quarterly meetings of the Injury Prevention Advisory Council (IPAC) which is coordinated by the IPAC Chair, which is the current Injury Prevention Epidemiologist.

The ISDH Injury Prevention Epidemiologist updated the "Injuries in Indiana" data report for 2007 to 2010.

ISDH continued to work with the Injury Prevention Advisory Council to share information with partners concerning programs and activities; and to coordinate information on preventing deaths and injuries from teen motor vehicle crashes as a topic area in the Indiana Adolescent Health Plan.

In 2012, ISDH purchased an EMS registry to capture all EMS runs in the state of Indiana and offer EMS provider's data they can use to improve their operations.

From June through September 2012, the Indiana State Department of Health held a statewide Trauma Listening Tour. Division of Trauma and Injury Prevention staff, along with local stakeholders, held "open house" style meetings in all 10 Indiana public health preparedness districts for Hoosiers to learn more about trauma, learn how state and local agencies currently respond to trauma, learn how a trauma system could help the state and, most importantly, gather personal stories of how trauma has affected those in Indiana. Another statewide Listening Tour took place beginning in April 2013.

The Indiana Criminal Justice Institute (ICJI) provided grants to the Automotive Safety Program (ASP), which funded 121 permanent fitting stations for infant and child car seats and booster seats through 5 local health departments.

Additional Injury Prevention training was incorporated into Healthy Families (home visiting) training.

ICJI supported a new E-code project where additional data was collected from ER visits and hospitalization records on the impact of MVA. The ISDH Injury Prevention Epidemiologist attended the meetings.

Sixty one acute care facilities with Emergency Departments entered data into the trauma registry.

On July 1, 2013, new law (IC 16-49) went into effect that moved the local child fatality review teams, and Statewide Child Fatality Review Committee, from Title 31 to Title 16, under the purview of the Indiana State Department of Health (ISDH). This new legislation required that each county, at the local level, implement either a county or regional child fatality review team, and that the ISDH create a coordinator position to help support and coordinate the local teams and Statewide Committee.

The purpose of child fatality review is, through the comprehensive, multidisciplinary review of the circumstances and risk factors involved in a child's death, child fatality review teams seek to understand how any why children die, take action to prevent other deaths, and improve the health and safety of our children.

ISDH, through the Preventive Health Block Grant, funded a portion of the child fatality review program coordinator position.

ISDH worked with the Statewide Child Fatality Review Committee to help develop standardized forms, processes, and a mission, vision, and goals statement for the Committee as well as the local child fatality review teams.

On September 23, 2013, the full-time child fatality review program coordinator position was filled.

In October 2013, there were a total of 8 teams, covering 16 Indiana counties, at some point in the process of implementing a local child fatality review team.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. . Indiana State Department of Health funds a full-time Director of Trauma and Injury Prevention, a full-time Injury Prevention Epidemiologist, and a portion of the child fatality review program coordinator position.				X
2. . ISDH Child Fatality Review Program Manager coordinates monthly state Child Fatality Review meetings and attends the meetings along with the Health and Human Services Commission Medical Officer.				X
3. ISDH hosts and the Health Commissioner leads the quarterly meetings of the Trauma Care Committee				X
4. ISDH completed a May 2012 Trauma White Paper which includes data on MV Death Rates and proposes the trauma system concept.				X
5. ISDH continues to work with the Injury Prevention Advisory Council, Statewide Child Fatality Review Committee, and local child fatality review teams to ensure transfer and transparency of information.				X
6. ISDH continues to coordinate information on preventing deaths and injuries from teen motor vehicle crashes as a topic area in the Indiana Adolescent Health Plan (pages 46-48).				X
7. The Injury Prevention Advisory Council is focusing on Motor Vehicle crashes with a recent review of the ICD-10 codes, hospitalization/ED rates, and death rates by age and sex from 2007-2010.				X
8. The Indiana Criminal Justice Institute provides grant funding to ISDH Injury Prevention for an e-code validation project, including chart review of hospitalizations due to motor vehicle crash injury		X		
9. ISDH is named as the lead agency responsible for development of a state trauma system				X
10. ISDH implemented an EMS registry in 2013 to capture all EMS runs in the state in order to compare with the trauma registry				X

#### **b. Current Activities**

ISDH funds a Director of Trauma & Injury Prevention, an Injury Prevention Epidemiologist, a portion of the child fatality review (CFR) program coordinator position, a full-time (FT) Trauma Registry Manager, a FT Trauma Registry Data Analyst & a FT EMS Registry Manager.

ISDH works with the Injury Prevention Advisory Council, the Statewide CFR Committee & local CFR teams to ensure information is shared with partners re: programs & activities involving injury prevention.

ISDH promotes auto safety through participation in relevant local/state programs. ICJI in partnership with IU Center for Criminal Justice Research gathers data and publishes the IN Traffic Safety Fact Sheets & IN Crash Fact book. ICJI provides grants to fund 122 permanent fitting stations for infant/child car seats & booster seats through 5 local health depts.

ISDH participates in establishing priorities for the Injury Prevention Program based on the State & Territorial Injury Prevention Association's 2010 needs assessment.

ICJI supports an E-code project where data is collected on e-code completeness of hospitalization records to improve the linkage of MVA records with hospital records by increasing the percentage of records with e-codes.

Eighty acute care facilities with Emergency Departments have entered data into the trauma registry from July 2013 to May 2014 (up from 49 last year).

ISDH is training members of the local CFR teams. In May 2014, there were 76 teams covering 79 counties.

### **c. Plan for the Coming Year**

ISDH, through the Preventive Health Block Grant, will continue to fund a full-time Director of Trauma and Injury Prevention and a full-time Injury Prevention Epidemiologist.

ISDH, through the Indiana Criminal Justice Institute, will continue to fund a full-time Trauma Registry Manager and a full-time Trauma Registry Data Analyst.

The ISDH Injury Prevention Epidemiologist will update the "Injuries in Indiana" data report. They will create new fact sheets about motor vehicle crash fatalities and hospitalizations.

ISDH will work with the Injury Prevention Advisory Council, Statewide Child Fatality Review Team, and local child fatality review teams to share injury data, identify areas where prevention efforts should be focused, and provide examples of prevention efforts including compiling proven policies and best practices.

ISDH will implement an EMS registry to capture all EMS runs in the state to compare with the trauma registry.

ISDH provided the Indiana School of Medicine a \$50,000 grant to study ATV injuries in rural Indiana.

ISDH toured the state twice talking about Trauma and Injury Prevention activities that the state is undertaking by way of a Trauma Registry Rule.

ISDH will promote automobile safety through participation in relevant local/state programs. The Indiana Criminal Justice Institute in partnership with Indiana University Center for Criminal Justice Research Center gathers data and publishes the Indiana Traffic Safety Fact Sheets and Indiana Crash Fact book. Indiana Criminal Justice Institute continues to provide grants to ASP, which funds 122 permanent fitting stations for infant and child car seats and booster seats through 5 local health departments: Boone County Health Department, Lebanon -Elkhart County HD, Elkhart -Henry County HD, New Castle -Marion County HD, Indianapolis -Spencer County HD, Rockport.

ISDH, through the Preventive Health Block Grant, will continue to fund a portion of the child fatality review program coordinator position.

ISDH will continue to work with the Statewide Child Fatality Review Committee to support the implementation of local child fatality review teams in all 92 counties.

ISDH will continue to provide training opportunities to members of the local child fatality review teams, members of the Statewide Committee, and the investigators of infant and child deaths.

ISDH will provide data from the local child death review teams to the Statewide Committee and assist the Committee in indentifying statewide child death trends and opportunities for prevention.

ISDH will provide data collected from the 2015 Youth Risk Behavior Survey (YRBS) to continue to coordinate information related to risky adolescent behaviors and motor vehicle use. The coordination of this data will assist in providing insight into the risky behaviors leading to teen injuries and deaths related to motor vehicle accidents and facilitate in the prevention of such injuries.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	36	37	38	39	40
Annual Indicator	31.4	35	31.4	39.2	39.2
Numerator					
Denominator					
Data Source	US CDC Report	US CDC Report	US CDC Report	US CDC Report	US CDC Report
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	41	42	43	42	42

**Notes - 2013**

2013 Data is based on trend analysis.

US CDC Report

**Notes - 2012**

2012 Data is final

**Notes - 2011**

2011 Data is final

**a. Last Year's Accomplishments**

There are now over 40 local breastfeeding coalitions covering Indiana's statewide. Three of these are minority coalitions.

The State Breastfeeding Coordinator (SBC) published a monthly e-newsletter that was distributed regularly to about 850 clinicians and other lactation community advocates as a tool for information dissemination, policy updates, and best practices.

Community drop-in centers continued to be available to provide community-based breastfeeding support.

ISDH and IPN hosted a third invitation-only Summit for administrators of all birthing hospitals. 97% of Indiana birthing hospitals were in attendance. Hospital mPINC scores and Baby-Friendly designations were discussed.

ISDH continues to serve on the Indiana Breastfeeding Coalition statewide committee to provide guidance on coalition development and outreach endeavors.

A Breastfeeding Resource Directory was created and published to enable access to resources by county.

A Breastfeeding Survey was conducted in birthing hospitals to assess practices associated with breastfeeding success as well as linking resources to community sources for the purpose of extending breastfeeding duration and exclusivity rates.

Created and disseminated a model template for breastfeeding for birthing hospitals.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Pursue licensure for lactation consultants so that consultations can be reimbursed through insurance				X
2. Create a model hospital template for breastfeeding.				X
3. Continue to build and develop local breastfeeding coalitions throughout the state, with a focus on minority populations.		X		
4. Assist with Baby-Friendly Hospital implementation for interested hospitals.				X
5. Continue to provide education and awareness for lactation support in the workplace.		X		
6. ISDH and IPN host the annual invitation-only hospital summit for administrators of all birthing hospitals in the state.				X
7. Indiana Breastfeeding Coalition will maintain and monitor resource directory on website.		X		
8.				
9.				
10.				

**b. Current Activities**

ISDH continues to explore insurance coverage for lactation consultation and supplies.

The State Breastfeeding Coordinator (SBC) will continue to increase, support and maintain local breastfeeding coalitions.

SBC will continue to provide expert advice to businesses and employees on the implementation of lactation support in the workplace.

ISDH is forming a comprehensive statewide task force in order to develop a strategic plan that



will address, among other items, extending Indiana's breastfeeding duration rates.

### c. Plan for the Coming Year

ISDH will work with National Institute on Child's Health Quality to formalize a strategic plan that will include SMART goals related to improving duration and exclusivity rates.

ISDH will explore legislative processes for reimbursement for IBCLC's consults and supplies to ensure continued access to professional breastfeeding support for families that need it.

Indiana Perinatal Network will work in conjunction with the Indiana Breastfeeding Coalition to maintain a directory of breastfeeding support for families and clinicians for all 92 counties.

ISDH and IPN will continue to work with hospitals who wish to become Baby-Friendly and/or improve their mPINC scores.

### **Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

#### Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	98.5	99.6	99.7	99.7	99.8
Annual Indicator	99.5	99.6	99.2	96.6	96.6
Numerator	85695				
Denominator	86126				
Data Source	ISDH - UNHS	ISDH - UNHS	ISDH- UNHS	ISDH- UNHS	ISDH- UNHS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	99.8	99.8	99.8	99.8	99.8

#### **Notes - 2013**

2013 Data is based on trend analysis.

ISDH-UNHS

#### **Notes - 2012**

2012 Data is final

ISDH\_UNHS

#### **Notes - 2011**

2011 Data is Provisional

## ISDH\_UNHS

### **a. Last Year's Accomplishments**

All of Indiana's birth hospitals and three midwifery facilities continue to use the EHDI (Early Hearing Detection and Intervention) Alerts Response System (EARS) web-based application that enables timely, accurate follow-up for children not receiving Universal Newborn Hearing Screening (UNHS), not passing UNHS and those passing but at risk for developing hearing loss after birth. To further improve screening results in the northeastern Amish communities one physician's group was loaned hearing screening equipment and began offering screenings June 2013. They were recently re-trained on its use (due to staff turnover) and wish to include this more in to their patient care regime.

In February 2014, the Indiana EHDI program submitted summary data to the Center for Disease Control and Prevention for children born in 2012. The data indicated that 96.6% of all babies born in Indiana were screened for hearing loss and 2.9% (2,364) did not pass UNHS. Follow-up for babies who did not pass indicated that 74.7% of the babies were found to have normal hearing, 6.1% of the babies were diagnosed with permanent hearing loss, 8.9% of families were unresponsive to our follow-up efforts and 1.9% of the babies were lost to follow-up. Indiana's lost to follow-up rate has remained stable over the past 2 years. The number of children who receive diagnostic follow-up before 3 months of age continues to increase. Overall, in 2012 EHDI was able to report 309 children were diagnosed with permanent hearing loss (145 did not pass UNHS, 24 passed UNHS, did not receive UNHS or were born in a different state, and 140 were born in previous years).

Since the inception of the Guide By Your Side (GBYS) program in September 2009, 440 families have enrolled in GBYS with 101 of those families enrolling in 2013. GBYS has continued to match families based on geographic location, language spoken in the home (English or Spanish), or type of hearing loss (unilateral or bilateral). Indiana GBYS includes 7 regional parent guides and 4 specialized parent guides including a guide for parents with a child with a unilateral hearing loss, a guide for Spanish speaking parents, a guide for parents with a child with a hearing loss and any additional developmental delay and a guide for parents who are Amish who have a child with a hearing loss. The average number of contacts with newly identified families, since our inception in 2009, is 10.1.

In 2013 EHDI staff continued to provide numerous presentations to physicians, audiologists, families, early interventionists and others at a variety of educational meetings and conferences including the Annual EHDI Conference, the EHDI Family Conference, and two First Steps provider forums.

On March 16, 2012, Governor Daniels signed Indiana House Enrolled Act 1367 (IC 4-3-22-18; (12) HE1367.1.1) which established a Center for Deaf and Hard of Hearing Education (CDHHE). The CDHHE opened July 1, 2013. The center is charged with the monitoring and tracking of children and students birth through school exit. The Indiana EHDI Program is physically located at the CDHHE but because of privacy issues remains organizationally located with the Genomics and Newborn Screening Program within Maternal and Children's Health.

It is anticipated that the current EHDI Alert Response System (EARS) will be used to track children's status beyond the EHDI process. The Indiana State Department of Health was responsible for establishing the CDHHE which currently has one centralized location on the campus of the Indiana School for the Deaf. Four regional locations across the state are in the planning stages and are slated to open during the 2015 fiscal year.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. Continue to work with individual hospitals to train new staff members and to encourage timely reporting of children in need of follow-up into the EARS web-based data system.			X	
2. Continue efforts to educate physicians regarding follow-up for children not passing UNHS and children at risk for delayed onset hearing loss.				X
3. Continue to refine EARS reports and the Integrated Data Store (IDS) to enable more timely analysis of program progress.			X	
4. Continue partnership with Indiana Hands & Voices to provide family education and support services.		X		
5. Provide two large trainings to audiologists on audiology procedures and related content areas to increase the skills, knowledge base and number of providers who serve very young babies and children				X
6. Continue to work with Level 1 and Level 2 centers to maximize audiologic services for infants and young children.			X	
7. Continue development of a comprehensive program evaluation with assistance from CDC EHDI team members.			X	
8.				
9.				
10.				

#### **b. Current Activities**

The EHDI program continues to monitor the submission of reports by hospitals (monthly summary reports or MSRs) and has provided ongoing technical assistance to hospitals having difficulties following recommended reporting practices. In addition, the EHDI program, including the EHDI Follow-up Coordinator and Parent Consultants, will continue to provide follow-up and support to families with children who did not pass newborn hearing screening and those children at risk for delayed onset hearing loss.

The EHDI program will continue to disseminate and track loaner equipment to hospitals, birthing facilities and audiologists in areas of the state where screening or comprehensive diagnostic evaluations are not readily available.

Indiana Hands & Voices continues to provide family-to-family support for parents as they proceed through EHDI process through the Guide By Your Side (GBYS) Program including support to specific groups of families (i.e., Spanish speaking, parents with children with unilateral hearing loss, bilateral hearing loss or auditory neuropathy.)

Gayla Hutsell Guignard became the Director of CDHHE and Julie Schulte became the Interim EHDI Director while also continuing with her role as the EHDI Follow-up Coordinator. Plans to hire a new EHDI program director were put in to place in January 2014 and the position filled April 2014. A new EHDI Follow-up Coordinator will hopefully be in place by mid-year 2014.

#### **c. Plan for the Coming Year**

EHDI staff will continue to strive to meet the national EHDI goals of 1) screening all babies by one month of age, 2) ensuring confirmation of hearing status before three months of age, 3) enrollment of children with diagnosed hearing loss in to appropriate intervention services by six months of age, and 4) assisting families in connecting with a medical home for provision of coordinated medical care.

As mentioned previously, the EHDI program continues to be organizationally within the Genomics

and Newborn Screening program but is physically located at the CDHHE. The EHDI staff continues to assist the CDHHE and with implementation of new statewide procedures to reduce the proportion of children who become lost to follow-up as they travel throughout the EHDI process, from screening to diagnosis to entry into intervention services.

In addition as part of the Center's development, EHDI conducted surveys with parents, hospitals, early intervention providers, midwives and physicians.

Genomics and Newborn Screening staff will continue to support the EHDI program by beginning to receive hearing screening results directly from hearing screening equipment (Oz Project) and through continued use of the Data Audit and Management Tools by increasing the number of children with documented UNHS results and reducing the number of duplicate files in IDS.

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	7.5	7.3	7	6.7	6.5
Annual Indicator	7.0	7.0	6.8	8	8
Numerator	111256	126000			
Denominator	1589365	1800000			
Data Source	Kids Count Bk	Kids Count Bk	Kids Count Bk	Kaiser Family Foundation	Kaiser Family Foundation
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	6.1	6	6	6	6

**Notes - 2013**

2013 data is based on trend analysis.

0-18 years of age

Source: Kaiser Family Foundation

**Notes - 2012**

2012 data is final

Data is for 0-18 years of age

Source: Kaiser family

## Notes - 2011

Based on trend analysis.

### a. Last Year's Accomplishments

The MCH ECCS initiative (Sunny Start: Healthy Bodies, Healthy Minds) provided service information to families via the Early Childhood Meeting Place website. The Financial Fact sheets were updated and many new topics were added. The sheets have been translated into Spanish. "Hits" to the website are tracked on Google Analytics. Outreach to medical providers about the availability of the information improved distribution to families.

MCH grantees served as enrollment sites for Hoosier Healthwise or referred clients to local Hoosier Healthwise enrollment sites. MCH required grantees providing primary care to children to be Medicaid providers.

The Indiana Family Helpline provided referrals and screened clients for Hoosier Healthwise eligibility.

MCH staff worked with Covering Kids & Families (CKF) to advocate for health coverage for IN families and participated on the Health Policy and Early Childhood Subcommittees. The Director of CKF served as Chair of the ECCS Evaluation/Data Committee and provided regular updates to the Committee and the ECCS Core Partners regarding insurance enrollment trend data of Hoosier children.

The Children's Special Health Care Services (CSHCS) Division provided funding to its Title V grantees for the purpose of having them speak with families about a variety of health insurance options (such as private, public, Medicaid Waivers, CSHCS Program, SSI, etc.) and assisted families in navigating through these complex systems. Many projects utilize the Sunny Start Financial Fact Sheets.

The CSHCS Care Coordinators discussed with children and youth with special health care needs (CYSHCN) and their families health care financing options through the CSHCS Program and other state programs. The CSHCS Program continued to send all participants aged 17-20 years of age information on their insurance options as they age off Hoosier Healthwise and the CSHCS Program.

The CSHCS Program continued to monitor those CSHCS participants who may also be dually eligible for Hoosier Healthwise on a quarterly basis. Once the program determines that a participant may be eligible for Hoosier Healthwise based on their federal poverty level (FPL), letters are sent out to the family to apply. The family has 21 days to comply.

Both Maternal, Infant, Early Childhood Home Visiting (MIECHV) Programs (Healthy Families Indiana and Nurse-Family Partnership) are required to assist families in signing up their children for Medicaid if they are not currently enrolled.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCH Sunny Start: Healthy Bodies, Healthy Minds initiative provides service information to families via a website. The website has been expanded to include more information including translation of all materials into Spanish.				X
2. MCH grantees serve as enrollment sites for Hoosier Healthwise or will refer clients to local Hoosier Healthwise enrollment sites.		X		
3. The Indiana Family Helpline provides referrals and screens clients for Hoosier Healthwise eligibility.		X		

4. MCH requires all grantees providing primary care to children to be Medicaid providers.		X		
5. The MCH Director serves on the Board of Covering Kids & Families, which advocates for health coverage for Indiana families and MCH staff participate on the Health Policy and Early Childhood subcommittees.				X
6. Both Maternal, Infant, Early Childhood Home Visiting (MIECHV) Programs (Healthy Families Indiana and Nurse-Family Partnership) are required to assist families in signing up their children for Medicaid if they are not currently enrolled.	X			
7.				
8.				
9.				
10.				

#### **b. Current Activities**

MCH ECCS Initiative Financial Fact Sheets are being updated/translated to Spanish/posted on the Early Childhood Meeting Place website.

MCH grantees serve as enrollment sites for Hoosier Healthwise (HH) or refer clients to local HH enrollment sites. The IFHL provides referrals & screen clients for eligibility.

MCH staff works with CKF & participates on the Early Childhood Subcommittee. The Executive Director of CKF participates at the quarterly Core Partners meetings & shares info: insurance enrollment trend data.

The CSHCS Program provides updates to providers & participants; oversees the electronic coordination of benefit (COB) process for medical & dental claims; enhances & tracks insurance & Medicaid utilization in the ACAPS system; reviews & follows-up on system reports created to identify COB issues for pharmacy claims; sends bulletins to providers to clarify the programs reimbursement method; & coordinates with pharmacies to ensure that proper methods for billing insurance information are used.

The CSHCS Program monitors participants who are dually eligible for HH on a quarterly basis.

CSHCN provides funding for a satellite CSHCS office at Riley Children's Hospital to assist families to apply for Medicaid & the CSHCS Program.

The CSHCS Division funds Title V projects for staff to speak with families about health insurance options & help families navigate through complex systems.

The IN Adolescent Health Plan (age 10 - 24) includes a priority on access to health care.

#### **c. Plan for the Coming Year**

Both Maternal, Infant, Early Childhood Home Visiting (MIECHV) Programs (Healthy Families Indiana and Nurse-Family Partnership) will continue to assist families in signing up their children for Medicaid if they are not currently enrolled.

MIECHV benchmark reporting includes data collection on children's insurance status at intake for baseline data (baseline will be complete in June 2014), and then again post-enrollment in order to measure how home visiting effects insurance status.

The MCH ECCS Initiative's Financial Fact sheets will be updated and new topics will be added, as appropriate. The information will be translated into Spanish and posted on the Early Childhood Meeting Place website.

MCH grantees will continue to serve as enrollment sites for Hoosier Healthwise or refer clients to local Hoosier Healthwise enrollment sites.

The IFHL will continue to provide referrals and screen clients for Hoosier Healthwise eligibility. MCH will continue to require all grantees providing primary care to children to be Medicaid providers.

MCH staff will continue to work with CKF and to participate on the Health Policy and Early Childhood Subcommittees.

The CSHCS Program will continue to provide updates to providers and participants; overseeing and improving the electronic coordination of benefits (COB) process for medical and dental claims; enhancing the ACAPS system; reviewing and following-up on system reports that were created to identify COB issues for electronic pharmacy claims; sending bulletins to providers which clarifies the programs reimbursement methodology; tracking insurance and Medicaid utilization in ACAPS; will also coordinate with pharmacies to ensure that proper methods for billing insurance information are being utilized.

The CSHCS Division will continue to provide funding for a satellite CSHCS office at the Riley Hospital for Children.

The CSHCS Care Coordinators will continue to discuss with CYSHCN and their families available options for health care financing through the CSHCS Program and other state programs.

The CSHCS Program will continue to monitor those CSHCS participants who may also be dually eligible for Hoosier Healthwise on a quarterly basis.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	30	36.5	36.5	31	31
Annual Indicator	36.5	31.3	31.4	30.7	30.7
Numerator	21292	26776	26371	25316	24068
Denominator	58260	85683	84091	82347	78469
Data Source	ISDH - WIC pgm	ISDH - WIC pgm	ISDH- WIC pgm	ISDH- WIC pgm	ISDH- WIC pgm
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	30	30	30	30	30

**Notes - 2013**

2013 Data is final.

ISDH-WIC-program

**Notes - 2012**

2012 data is final

**Notes - 2011**

Data is final.

**a. Last Year's Accomplishments**

WIC staff screen all applicants for Risk Factor (RF) 113 (Obese/BMI > 95%), RF 114 (Overweight/BMI > 85% to < 95%) and RF 115 High Weight for Length for Infants and Children < 24 months of age (> 97.7th percentile based on the WHO growth standards). MCH health care professionals also screened all participants for "Overweight" (BMI = or > 95%) and "At Risk for Overweight" (BMI 85% to < 95%) status using height for weight BMI.

WIC health professionals and MCH clinics assessed WIC eligible children's diets for nutrition, feeding practices and eating habits that would affect growth patterns.

When appropriate, WIC staff provided counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. Where appropriate, MCH clinics provided guidelines on healthy eating habits and physical activity to families and children. Created guidance for WIC health professionals, based on Participant Centered Services (PCS), to explore with parents their child's growth including positive word selection and approaches to reach a healthy weight and increase activity.

WIC and MCH clinics displayed posters/bulletin boards communicating information on physical activity, nutrition and healthy eating.

WIC and MCH clinics provided educational materials (books, handouts, videos, handouts/fliers) on healthy eating and physical activity.

MCH supported Division of Nutrition and Physical Activity (DNPA) initiatives, objectives and strategies in the reduction of percentage of children, ages 2 to 5 years, with a Body Mass Index at or above the 85th percentile.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC and MCH health professionals are screening all applicants for Risk Factor 113 (Overweight/BMI = or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%).	X			
2. WIC health professionals are assessing WIC eligible children's' diets for nutrition and feeding practices that would affect growth patterns. MCH clinics assess children's diets for nutrition and eating habits that would impact growth patterns.	X			
3. When appropriate, WIC provides counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. Where appropriate, MCH clinics provide guidelines on healthy eating habits and physical activity.		X		
4. WIC displays posters/bulletin boards on physical activity, nutrition and healthy eating. MCH clinics display posters and create bulletin boards communicating information on physical activity, nutrition and healthy eating habits.		X		



5. WIC provides educational materials (books, handouts, videos) on healthy eating and physical activity. MCH clinics provide educational information (handouts/fliers) on healthy eating and physical activity.		X		
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

WIC staff screens for Risk Factor (RF) 113 (Obese/BMI > 95%), RF 114 (Overweight/BMI > 85% to < 95%) and RF 115 High Weight for Length for Infants and Children < 24 months of age (> 97.7th percentile based on the WHO growth standards). MCH health professionals screen all participants for "Overweight" (BMI > 95%) and "At Risk for Overweight" (BMI 85% to < 95%) status using height for weight BMI.

WHO growth grids are used in all WIC clinics for infants & children up to age 2. The computer plots each participant's chart growth grid based on length/height & weight.

WIC provides participant centered counseling to families of WIC eligible children. A chart is available for health professionals to use for assessing nutrition concerns & explore areas for behavior change. MCH clinics provide information on healthy eating/physical habits & family activities.

The IN WIC Nutrition Education Plan was revised to include decreasing childhood obesity as a main topic through 2016. The Plan addresses healthy eating & childhood obesity by promoting the use of vouchers for fresh/frozen fruits & vegetables.

Quarterly performance measures (PMs) have been established as tools for performance management for local WIC agencies. Two measures cover the # of obese children & cash-value voucher redemption for the families. Local agencies may purchase nutrition education materials for physical activity, healthy weight, & fruit/vegetable awareness to support their services.

#### **c. Plan for the Coming Year**

WIC health professionals will screen all applicants for Risk Factor 113 (Obese/BMI equal or > 95%), Risk Factor 114 (Overweight/BMI > 85% to < 95%) and Risk Factor 115 High Weight for Length for Infants and Children < 24 months of age (> 97.7th percentile based on the WHO growth standards). Risk Factors 113 and 115 will continue to be designated as high risk factors. MCH health care professionals also screen all participants for "Overweight" (BMI equal to or > 95%) and "At Risk for Overweight" (BMI 85% to < 95%) status using height for weight BMI. WIC health professionals will continue to assess WIC eligible children's diets for nutrition and feeding practices that would affect growth patterns. Additional PCS tools, based on WIC participant categories, will be initiated in the WIC clinics for health professionals to use during their assessment and counseling.

Modifications will be made to the statewide WIC Nutrition Education Plan based on the findings from the FY14 summary report. This summary will be shared with all of the WIC local agencies to encourage successful innovative nutrition activities to impact children's health.

The WIC Performance Measurements for obese children and redemption of the cash-value vouchers will continue to be assessed for progress through positive outcomes and effective activities.

WIC will provide educational materials (books, handouts, videos) on healthy eating and physical

activity.

MCH to discuss healthy weight issues

MCH clinics will continue to provide educational and referral information on healthy eating habits, physical activity and family- and community-centered activities that support healthy nutrition and physical activity.

MCH will continue to support the Division of Nutrition & Physical Activity (DNPA) initiatives, objectives & strategies in the reduction of percentage of children, ages 2 to 5 years, with a BMI > the 85th percentile.

The MCH Child Health Coordinator will continue to participate in the DNPA Healthy Weight Initiative's Early Childhood Committee.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	15.6	17.5	17	15.2	14.1
Annual Indicator	15.3	14.3	14.2	13.8	13.8
Numerator	13157	12025	11879	11475	
Denominator	86126	83867	83890	83250	
Data Source	ISDH - VR	ISDH - ERC	ISDH-ERC	ISDH-ERC	ISDH-ERC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	14	14	13.9	13.9	13.9

**Notes - 2013**

2013 Data is based on trend analysis

Source of data: ISDH – ERC

**Notes - 2012**

2012 Data is provisional.

Source of data: ISDH – ERC

**Notes - 2011**

2011 Data is based on trend analysis

Source of data: ISDH – ERC

**a. Last Year's Accomplishments**

MCH continued to be an active member of the Promoting Smoke Free Pregnancy leadership team.

Implemented new cessation techniques, the Baby & Me Tobacco Free (BMTF) program, in 8 sites around Indiana.

Conducted ongoing assessment of prenatal smoking data using monthly NOP data; vital records, Title V funded project quarterly reports, by county, race, Medicaid versus Non-Medicaid.

In partnership with the Tobacco Prevention and Cessation Division, continued to promote and encourage use of the Quitline for pregnant women, as well as educate the populace on the dangers of smoking while pregnant.

Created and disseminated prenatal smoking data briefs based on age, race/ethnicity, insurer, and geographical location of the targeted population, as a component of the Education Committee of the Indiana Perinatal Quality Improvement Collaborative.

MCH and Indiana Perinatal Network used data briefs to educate health care providers, local health department staff, community policy leaders, and consumers about the prevalence of smoking during pregnancy, including the consequences of smoking before, during and after pregnancy, best practice models for awareness activities to target low income women, and proposed best practice models to decrease smoking among women of childbearing age across the lifespan.

All MCH Title V funded projects are mandated to ask all pregnant women if they smoke and then assist smokers to quit. Ongoing trainings with trainings with Title V funded projects and BMTF programs continued.

Initiated a quality improvement project aimed to determine the optimal threshold for contingency management as a tobacco cessation effort.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Members of the PSPI training subcommittee will continue to provide regional trainings throughout the year for health care providers working with pregnant women.		X		
2. Implement BMTF programs for pregnant women throughout Indiana	X			
3. Conduct ongoing assessment of prenatal smoking data using monthly NOP data; vital records, Title V funded project quarterly reports, by county, race, Medicaid versus Non-Medicaid.			X	
4. Create and disseminate prenatal smoking data briefs to prenatal care provider, local health departments, and community policy leaders.			X	
5. Disseminate best practice models to decrease smoking among women of childbearing age across the lifespan.				X
6. Initiate a quality improvement project for community clinics to study contingency management in prenatal smoking cessation.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

Continue to explore best practices for treating smoking as a co-morbidity adverse health behavior with mental health problems.

Working with Promoting Smoke Free Pregnancy to provide training to prenatal care providers on assessment of mental health problems in all patients that smoke.

Encouraging Medicaid to add mental health assessment for high risk pregnant women who continue smoke during pregnancy.

Encouraging prenatal care providers to code smoking in pregnancy as a substance use disorder when appropriate and refer to local Department of Mental Health and Addictions programs for treatment.

Continuing to be a member of the Promoting Smoke-Free Pregnancies in Indiana Coalition. Provide data analysis, policy recommendations, and assist with provider trainings.

Monitoring vital record data for number of pregnant smokers who quit before delivery.

Monitoring vital record data for number of pregnant women who smoke in their last trimester.

Updating State website with pertinent prenatal smoking information include facts, figures and resources.

Continuing the Baby & Me Tobacco Free Program (BMTF) in 8 funded sites throughout Indiana to address tobacco use during pregnancy.

Collaborating with Tobacco Prevention and Cessation to discuss options for best practices programs for future cessation services.

Encouraging women to enroll in services such as the Indiana Quitline and BMTF. These programs not only help women become smoke free during their last trimester, but also after the birth.

**c. Plan for the Coming Year**

MCH continues its partnership with the Indiana University Schools of Public Health in both Bloomington and Indianapolis. This partnership will involve clinics in three Indiana counties, use biochemical means to get accurate quit rates and employ contingency management techniques to aid in cessation efforts.

MCH will expand the Baby & Me Tobacco Free Program to allow the baby's father to participate in this evidence-based contingency management program as a pilot to address the common barrier of lack of family support during the quit attempt. The target of this program will continue to be Medicaid eligible families in Indiana. Of special focus, is the quit rate for women and their families during their pregnancy, but also after delivery.

MCH will continue to sit on the Promoting Smoke Free Pregnancy leadership team. The team is focusing on providing workshops and technical assistance to communities throughout Indiana whose goal is to lower their prenatal smoking rates.

Indiana Perinatal Network will continue to be instrumental in delivering provider education during their statewide training series.

Continue to encourage providers to screen for tobacco use.

Prenatal Smoking Cessation has been adopted by the Perinatal Quality Improvement group's Education Committee as a high impact focus to reduce maternal and infant morbidity and mortality.

MCH will continue to engage in conversation with the Office of Medicaid Policy and Planning and Managed Care Entities to expand BMTF in Indiana and improve awareness of this program in communities throughout Indiana.

Title V funded partners continue to screen for tobacco use during visits.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	6.9	9	9	8.6	8.5
Annual Indicator	8.7	8.0	9.6	11.1	11.1
Numerator	40	38	45	51	
Denominator	460787	473975	468801	458363	
Data Source	ISDH - ERC	ISDH - ERC	ISDH-ERC	ISDH-ERC	ISDH-ERC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	8.5	8.4	8.5	8.5	8.5

**Notes - 2013**

2013 data is based on trend analysis.

ISDH-ERC

**Notes - 2012**

2012 data is provisional.

Source of data: ISDH - ERC

**Notes - 2011**

2011 data is final.

Source of data: ISDH - ERC

**a. Last Year's Accomplishments**

SAHC partnered with organizations through the Indiana Coalition to Improve Adolescent Health (ICIAH) to implement recommendations regarding the prevention of suicidality as noted in the

state adolescent health plan.

SAHC worked with other internal staff at ISDH to collaborate on injury-prevention activities related to the prevention of suicide among adolescents.

SAHC supervised the YRBS Coordinator, who disseminated data from the 2011 YRBS, highlighting findings related to various health risk behaviors, including thoughts of suicide, attempted suicides, and feelings of sadness and depression.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SAHC partnered with organizations through the ICIAH to implement recommendations regarding the prevention of suicidality as noted in the state adolescent health plan.				X
2. SAHC worked with other internal staff at ISDH to collaborate on injury-prevention activities related to the prevention of suicide among adolescents.				X
3. SAHC supervised the YRBS Coordinator to disseminate data findings from the 2011 survey, including thoughts of suicide, attempted suicides, and feelings of sadness and depression. SAHC also assisted with the administration of the 2013 YRBS Survey.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

SAHC is partnering with organizations through the ICIAH to implement recommendations regarding the prevention of suicidality as noted in the state adolescent health plan.

SAHC is working with other internal staff at ISDH to collaborate on injury-prevention activities related to the prevention of suicide among adolescents.

SAHC is supervising the YRBS Coordinator to disseminate data findings from the 2011 survey, highlighting findings related to various health risk behaviors, including thoughts of suicide, attempted suicides, and feelings of sadness and depression. SAHC is also assisting in the administration of the 2014 School Health Profiles Survey, which is collecting data from school administration regarding school initiatives related to student mental health and wellbeing. The SAHC is also assisting with the administration of the 2015 YRBS Survey.

**c. Plan for the Coming Year**

SAHC will continue supervising the YRBS Coordinator to disseminate data findings from the 2011 YRBS survey and the 2014 School Health Profiles Survey, highlighting findings related to various health risk behaviors, including thoughts of suicide, attempted suicides, and feelings of sadness and depression.

SAHC will continue partnering with organizations through the ICIAH to implement recommendations regarding the prevention of suicidality as noted in the state adolescent health plan, and look for additional funding opportunities.

SAHC will continue working with other internal staff at ISDH to collaborate on injury-prevention activities related to the prevention of suicide among adolescents.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	80	70	82	87	87
Annual Indicator	85.3	77.0	86.1	69.8	69.8
Numerator	1015	905	989	776	
Denominator	1190	1175	1149	1112	
Data Source	MCH Cons Pgm	ISDH – ERC	ISDH – ERC	ISDH – ERC	ISDH – ERC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	69.8	69.8	69.8	69.8	69.8

**Notes - 2013**

2013 Data based on trend analysis.

ISDH-ERC

**Notes - 2012**

2012 Data is based on trend analysis and on self-reported hospital's level of care

Source of data: ISDH – ERC

**Notes - 2011**

2011 Data is Provisional based on self-reported hospital's level of care

Source of data: ISDH – ERC

**a. Last Year's Accomplishments**

Preliminary Natality data for 2012 shows that 69% of very low birthweight infants were born at self declared Level 3 hospitals. The Indiana Perinatal Quality Improvement Collaborative (IPQIC) is addressing this issue with creation of a state perinatal system that brings all hospitals together in

a collaboration to improve perinatal outcomes.

On January 14, 2013 Dr. William VanNess was appointed by Governor Pence as the Indiana State Health Commissioner. In February, 2013, Dr VanNess identified reduction in infant mortality rates as the top priority for the State Health Department for the next four years.

The Indiana Perinatal Hospital Level of Care Standards were approved by the Indiana Perinatal Quality Improvement Collaborative (IPQIC) Governing Council and ISDH. The Council is made up of The State Health Commissioner, and the President of the Indiana Hospital Association as co-chairs; representatives from the Indiana Medical Association, INACOG, INAAP, INAAFP, INAWHON, IN Medicaid, IN Family Social Services Administration, IN Department of Insurance, Anthem Insurance, Indiana Primary Health Care Association, Indiana Rural Health Association, Fairbanks School of Public Health, IN Perinatal Network, IN March of Dimes, WellPoint, IN Minority Health Coalition, Director, Indiana State Department of Health (ISDH) Division Maternal Child Health, ISDH Director Office of Primary Care, and a Consumer.

The approved hospital guidelines were sent to all 92 birthing hospitals to collect information of where each hospital stands as of this time period and where they need to be to qualify the level of ob and neonatal care they think they are. A Gap Analysis was conducted and major gaps in appropriate personnel, required equipment and required policies were found. 18 hospitals self reported as a level 3 OB, but only 3 actually met all the standards. 24 hospitals self-reported as a level 3 NB, but only 3 actually met all the standards. Two hospitals declared themselves as a level 4 NB and they met all the standards. Hospitals were notified of the Gap Analysis results. The Gap analysis process was very well received by the hospitals, and they are working to fill gaps and solidify their level. Several hospitals have voluntarily decreased their self-declared level of care, but 3 hospitals refused to complete the gap analysis.

The Hospital Level of Care Standards Implementation Committee completed the Indiana Perinatal Standards of Levels of Care Certification Process and adapted the Michigan flowchart for Indiana. Three parts of the certification process include 1) application for certification by level with supporting documents for each Level of Care, 2) onsite certification process and documentation, and 3) corrective action/waiver. The committee is still working on which standards are likely areas for corrective action and which standards are not eligible for waiver. The Maternal-Fetal and Newborn Transport Committee surveyed all OB units, newborn and NICUs for a gap analysis of availability of current transport systems, policies, MOUs, and needs. Payment for back transport is an issue that needs to be clarified. As was expected there are large gaps in services in some parts of the state. Transportation standards for maternal-fetal and newborn transport were begun. All standards were based on evidence-based guidelines. Maryland and Illinois have been studied as examples.

The Perinatal Centers committee is defining what regional perinatal centers should look like, their roles, responsibilities, structure. The Perinatal Centers are modeled after Centers in New York. The Perinatal Centers will pull the new statewide perinatal system together. Initial work has been presented to the Governing Council and the recommendations were approved by consensus.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop a state perinatal database.				X
2. Begin piloting the birthing hospital certification process.				X
3. Identify hospitals that meet requirements for being a Perinatal Center.				X
4. Begin process to make the Indiana Perinatal Hospital Level of Care Standards rules.				X



5. Disseminate perinatal transport standards to all hospitals				X
6. Work with Indiana Homeland Security and EMS to incorporate perinatal standards into state EMS rules.				X
7. Assess hospital outcome data by region and share data with hospitals and Health Officers by region.			X	
8. Fund the Indiana IVON Neonatal Collaborative to conduct the cord milking and delayed clamping study at all Level 3 NICUs participating in IVON.			X	
9. Continue to provide facilitation, technical assistance and consultation to all IPQC committees.				X
10.				

#### **b. Current Activities**

ISDH will begin the process to make the hospital perinatal standards rules. MCH will begin to Beta test the certification process with pilot hospitals. Masters level nurses with hospital experience in high risk ob and neonatal care have been interviewed and will be hired soon. July is the target date for them to start. This is not certification. When the kinks are worked out of the process and procedures, any hospital can apply for a voluntary site visit.

The new IPQIC Finance Committee is reviewing innovative reimbursement strategies, such as social impact bonds being tried in other states.

The IPQIC Governing Council unanimously approved the Coordinated Perinatal Systems of Excellence (Perinatal Centers), the finalized Perinatal Transport Standards, and the Regional County Data Dashboards.

ISDH Health Commissioner sends a monthly letter to all birthing hospitals with updates from IPQIC and ISDH concerning work on the new Perinatal System.

MCH is funding the second project of the Indiana I-VON Neonatal Quality Improvement Collaborative to conduct the cord milking, and delayed cord clamping study at 12 Level 3 NICUs participating in I-VON. Twelve NICUs participate. Jasper County closed their ob unit in May. There are now 29 counties (31%) without a birthing hospital.

Level 3 OB/NICU hospitals that qualify to be a Perinatal Center of Excellence will meet in July to discuss the requirements and process.

The 5th perinatal hospital summit will occur 9-5-2014.

#### **c. Plan for the Coming Year**

Collaborate with March of Dimes, the Indiana Hospital Association, IN Medicaid, Indiana Rural Health and the Office of Primary Care to address loss of perinatal providers, and hospitals in Indiana. Explore how surrounding states will fit into the new perinatal system to provide quality high risk perinatal care when needed.

Continue development of state perinatal database to capture real time data from hospitals and providers to produce rapid cycling evaluation. Maternal and infant indicators will be identified and agreed on by all perinatal database partners. Analysis of indicators by hospital will occur and a hospital dashboard report will be published bi-annually on the ISDH website.

Conduct a state PPOR, and identify counties to do local PPORs.

Conduct a state FIMR. Develop a state review team. Collaborate with the state child fatality

review team.

When rules for hospital standards are complete the certification process of hospitals will begin. Hospitals that are certified will be listed on the ISDH website for transparency. Hospitals that refuse certification will also be posted. Transport standards will be incorporated into the Indiana Perinatal Hospital Standards.

Funding for the Indiana IVON Neonatal Collaborative Cord Milking Project will continue through FY2015.

The state maternal mortality review will work with INACOG and Perinatal Centers to receive hospital sentinel reports of maternal deaths.

Continue to monitor inductions, cesareans, and neonatal deaths.

Senate Enrolled Act No.408 Neonatal Abstinence Syndrome instructs the State Department of Health to meet with Indiana Hospital Association, Indiana Perinatal Network, Indiana State Medical association, Indiana Chapter of AAP, Indiana Section of ACOG, Indiana Chapter of March of Dimes to develop a clinical definition of Neonatal Abstinence Syndrome (NAS), develop uniform process of indentifying NAS, estimate time and resources needed to educate hospital personnel in implementing an appropriate and uniform process for identification and management of NAS, identify and review of appropriate data reporting options, identify whether payment methodologies for identifying NAS and data reporting are currently available or needed. Since of these entities are on the IPQIC Governing Council This process has been made part of the Governing Council responsibilities and the Quality Improvement Committee.

By June 15, 2015, ISDH will establish pilot projects with volunteer hospitals to get a handle on the incidence of newborn abstinence syndrome in Indiana. A pilot newborn screening for opioids will be explored, as well as a hospital survey of all newborn units in the state. Development and piloting of a data collection and reporting tool will also occur. A statewide NAS initiative will be developed based on findings.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	77.5	66	68	70	72
Annual Indicator	66.1	68.5	68.0	68.4	68
Numerator	56966	57435	57066	56912	
Denominator	86126	83867	83890	83250	
Data Source	ISDH - ERC	ISDH - ERC	ISDH- ERC	ISDH-ERC	ISDH-ERC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

	2014	2015	2016	2017	2018
Annual Performance Objective	74	75	76	75	75

#### Notes - 2013

2013 Data is based on trend analysis.

ISDH-ERC

#### Notes - 2012

2012 Data is provisional.

ISDH – ERC

#### Notes - 2011

2011 Data is based on trend analysis

Source of data: ISDH – ERC

#### a. Last Year's Accomplishments

Preliminary 2012 data shows that 68.4% of all women initiated prenatal care in the first trimester. 21 counties had a significantly higher rate than the state and 10 counties had a significantly lower rate than the state. In 2012 entrance into prenatal in the first trimester for Black women improved 9.1% since 2008 (52.6%) to 2012 (57.4%) (2012 provisional data).

It appears that counties with the most success in early prenatal care access had an excellent relationship with the County Office of Family and Children which houses Medicaid. This increased understanding of the Medicaid application process and the ability of Title V funded staff to effectively assist low income women in completing a successful application makes a difference in access to care. While all Title V funded prenatal services are mandated to assist women with Medicaid application, some projects are doing a better job.

In February, 2013, State Health Commissioner Dr. VanNess announced Infant Mortality was a state priority. A state plan was developed which included increasing access to early prenatal care.

Medicaid Presumptive Eligibility (PE) was started in July, 2009 to address Indiana's declining entrance into prenatal care in the first trimester. While PE has increased early entrance into prenatal care in some counties, there remains a number of counties still not participating in PE. The Office of Medicaid Policy and Planning (OMPP) is exploring expanding the PE program to include acute care hospitals.

MCH continues to fund the Nurse-Family Partnership, with funding from the Affordable Care Act Maternal Infant and Early Childhood Home Visiting Program.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess and address systems, provider, and individual barriers to accessing prenatal care, as well as local capacity to provide quality care.				X
2. Decrease disparities in access to early and ongoing prenatal care through a collaborative effort with Medicaid, Managed Care Entities, IPN, IPQIC, and funded projects at the local level.				X
3. Monitor birth certificate data on entrance into early prenatal			X	

care and include this information in a yearly dashboard to county health officer on Natality outcomes by race and county.				
4. Monitor PE and Medicaid enrollment through all funded prenatal projects.		X		
5. Collaborate with Medicaid, hospital emergency departments, and Med Check offices to send a notification of pregnancy to Medicaid when a pregnancy has been diagnosed.			X	
6. Restructure and build a comprehensive, collaborative system of providing case management services to high risk mothers.				X
7.				
8.				
9.				
10.				

#### **b. Current Activities**

A state infant mortality FOA was released October 2013 for local projects to impact infant mortality in FY 14-15. MCH is funding a new Early Start and 7 new prenatal care coordination programs as part of this initiative.

The first ISDH Infant Mortality Summit was held 11/1/2013. FOA technical assistance was offered.

The Family and Social Services Administration (FSSA) is submitting a request to the Centers for Medicare & Medicaid Services (CMS) to expand the accessibility of the existing HIP program to eligible Indiana residents with incomes up to 138 percent of poverty. The plan includes maternity care with no fees.

OMPP has expanded the Presumptive Eligibility (PE) program January this year to include acute care hospitals. Women seen the ER and diagnosed as pregnant can be enrolled in PE.

The 5th perinatal hospital summit will occur 9-5-2014. Current information on entrance into prenatal care and presumptive eligibility will be shared with all birthing hospitals.

#### **c. Plan for the Coming Year**

Funding for Infant mortality projects will continue through FY 2015. MCH should assess a cost benefit analysis of Early Start clinics for possible expansion. Early Start clinics begin services at the time of a positive pregnancy test for women without Medicaid, private insurance, or financially ability to access prenatal care with a physician in the first trimester. Pregnant women are voluntarily enrolled in the Early Start clinic. First encounter includes a health and pregnancy history, prenatal risk assessment, nutrition assessment, Ht/Wt/BMI, physical assessment, prenatal labs, vitamins, first trimester education, Medicaid enrollment if eligible, WIC referral, appropriate social referrals, and prenatal care coordination if available. Women not at high risk are seen in the clinic until she gets Medicaid or chooses to leave to be seen by a prenatal care physician. Some women may continue in the Early Start clinic until delivery if she remains uninsured and with no other medical provider.

With a heavy focus on PNCC to improve access to services, there is a need for a more rigorous program evaluation. PNCC outcomes forms will be linked to birth and infant death certificates as part of the evaluation. The plan is to also link PNCC patients with Medicaid Fee for Service and Managed Care claims and outcomes.

MCH will continue to work closely with Medicaid and the Medicaid Managed Care entities to collect accurate data on entrance into care, make data from all sources transparent, and improve marketing of Presumptive Eligibility at the local level.

As a member of the OMPP Neonatal Quality Improvement Committee, MCH will monitor the success and barriers of the Hospital Presumptive Eligibility (HPE), a new process that began in January of 2014. The Hospital Presumptive Eligibility (HPE) process allows acute care hospitals to make presumptive eligibility determinations for women who are found to be pregnant in the emergency room or through hospital admittance for another reason. Reimbursement for this PE program will be fee-for-service.

Promote Presumptive Eligibility at the local level by collaborating with local minority health coalitions, neighborhood baby showers, faith based organizations, WIC.

Work with local Black Minority Health Coalitions to Implement the Free Pregnancy Test Program in counties where Black pregnant women have a lower entrance into early prenatal care than the state rate.

## D. State Performance Measures

### State Performance Measure 1: *Rate of suffocation deaths of infants.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			15.3	15.2	15.1
Annual Indicator	16.4	10.5	12.6	15.6	15.6
Numerator	111	66	81	87	
Denominator	675	630	643	556	
Data Source	ISDH - ERC	ISDH - ERC	ISDH-ERC	ISDH-ERC	ISDH-ERC
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	15	14.9	14.8	15	15

#### Notes - 2013

2013 data is based on trend analysis.

ISDH-ERC

#### Notes - 2012

2012 Data is provisional.

Source ISDH-ERC

#### Notes - 2011

2011 Data is provisional

Source ISDH-ERC

#### a. Last Year's Accomplishments

The bi-annual State Safe Sleep conference, "Protecting Indian's babies: Safe Sleep and Breastfeeding" was held October 24, 2012. Speakers included Joan Duwve, MD, ISDH Medical Director, Rachel Moon, MD, Haywood Brown, MD, Duke University Health System, and Indianapolis Healthy Start. Featured topics included Cultural attitudes toward Bedsharing, new

AAP infant sleep recommendations, new crib guidelines, protective aspects of breastfeeding, and program sharing.

MCH collaborated with State of Indiana Department of Homeland Security First Responder Training: Web-based SUIDS Training for First Responders was completed. Under IC 36-10.5-7 all first responders in Indiana (police, fire, ems, ema, etc) are supposed to take on training over SIDS. This SIDS training, is supposed to be developed and approved by the EMS Commission and ISDH Commissioner. MCH was instrumental in expanding the training to include all SUIDS. The training and certification is web-based and is available at <http://www.in.gov/dhs/3142.htm>. There are tests for each module (5) and a final exam resulting in certification.

The state legislature made changes to the Child Fatality Review legislation. The new legislation signed by Governor Pence, calls for CF review teams in every county and a dedicated Child Fatality Coordinator that will be located with ISDH MCH.

MCH has funded with the State SIDS/SUIDS Coordinator as a contract position through the Indiana Perinatal Network (IPN). However, IPN chose to not to continue the contract with the State Coordinator going forward. The State SIDS/SUIDS Coordinator informed MCH that she was leaving her position in March 2013, to take a position with the National First Candle Organization as the national safe sleep training coordinator. The State SIDS/SUIDS Coordinator agreed to continue to provide limited consultation services to assist in finding a replacement State SUIDS Coordinator, and continue to facilitate the MCH Infant Health and Survival Council. The State Coordinator was invited to submit a proposal to ISDH for interim services.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Design population based interventions and education programs about safe sleep practices for infants that take into account the influence of social determinates and cultural differences			X	
2. Provide leadership to local partner organizations in coordinating local summits and in enlisting the resources of community organizations in efforts to reduce SIDS and infant suffocation in bed.				X
3. Facilitate statewide CDC death scene investigation training for coroners, medical examiners, law enforcement, EMS, deputy coroners and other possible first responders, through partnership with state training team.				X
4. Institutionalize FIMR reviews within local county child fatality review processed.			X	
5. Collaborate with the State Division of Child Services to facilitate their state-wide crib program.				X
6. Re-invigorate the MCH Community Council on Infant Health and Survival with Safe to Sleep Champions from each of the 10 ISDH Regions, as well as additional professional stakeholders.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

Gretchen Martin, MSW, Legislated State Child Fatality Review Program Coordinator was hired. Her first priority is to begin local Child Fatality Review teams in each county. While combining FIMR and CF reviews at the local and state level is a priority this may not happen until 2015.

MCH collaborates with Vital Records on training webinars on how to improve collection of accurate data on birth and infant death certificates to facilitate review of all infant deaths.

MCH has developed an ongoing partnership with the State Division of Child Services (DCS) when it was discovered that DCS was supporting a cribs for kids program and promoting safe sleep. MCH and DCS are collaborating on the hiring of a new State SUIDS Coordinator. Collaborate with DCS on their state-wide crib program and SIDS education.

Hire a new State SUIDS Coordinator to oversee Safe Sleep and statewide FIMR reviews and facilitate the merger of FIMR and CF, at the local and state level. Facilitate continued CDC infant death scene investigation training of all county first responders and coroners.

### c. Plan for the Coming Year

The State SUID Coordinator will partner with the State Child Fatality Review Program Coordinator to implement FIMR with CF in every county or region, and assist counties to design population based interventions and education programs about safe sleep practices for infants that take into account the influence of social determinates and cultural differences.

Continue to work with the MCH Infant Health and Survival Council, made up of volunteers from around the state, to address our high SUID death rate. Re-invigorate the MCH Community Council on Infant Health and Survival with Safe to Sleep Champions from each of the 10 ISDH Regions, as well as additional professional stakeholders.

The State SUID Coordinator will provide leadership to local partner organizations in coordinating local summits and in enlisting the resources of community organizations, faith-based groups, public health officials, and service organizations in efforts to reduce SIDS and infant suffocation in bed.

Plan and host the bi-annual SUIDS conference with help from the Community Council on Infant Health and Survival.

Perform a State analysis of all SUIDS with ICD-10 codes R95, W75-W84 as part of the state PPOR.

## **State Performance Measure 2:** *The percentage of mothers who initiate exclusive breastfeeding.*

### Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective			68.5	69	69
Annual Indicator	69.9	72.1	68.5	60.2	60
Numerator	60189	60477		49513	
Denominator	86126	83867		82252	
Data Source	ISDH/ERC	ISDH/ERC	ISDH/ERC	ISDH/ERC	ISDH-ERC
Is the Data Provisional or				Provisional	Provisional

Final?					
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	70	70	71	70	70

#### **Notes - 2013**

2013 data is based on trend analysis.

ISDH-ERC

#### **Notes - 2012**

2012 Data is provisional.

Source ISDH-ERC

#### **Notes - 2011**

2011 Data is based on trend analysis.

Source ISDH-ERC

#### **a. Last Year's Accomplishments**

The Indiana Breastfeeding Coalition (IBC) continued to build and maintain local breastfeeding coalitions and acted as a conduit for information and opportunity amongst the state and local chapters.

Technical assistance to hospitals wanting to pursue Baby Friendly designation was offered through the Indiana Perinatal Network (IPN).

Along with the IPN, contributed to the annual Hospital Summit which addresses perinatal issues for delivering hospital to high level leadership and clinical management. Lactation best practices were addressed.

The Maternal Health Administrator worked with the clinical committee of the IBC to develop a model template for hospitals in regards to breastfeeding practices. This template is available on the IBC website, as well as linked from the Indiana State Department of Health's (ISDH) Maternal Child Health breastfeeding home page.

A hospital lactation services survey was completed in order to determine delivering hospital's strategies and priorities for pursuing Baby Friendly designation, improving mPINC scores, banning formula bags, and other lactation-related initiatives.

A document that compiled breastfeeding resources statewide by counties was completed and is available online. Resources included: breastfeeding coalitions, drop-in centers, support groups, and breastfeeding classes. In addition, WIC locations, delivering hospitals, and La Leche League and Breastfeeding USA chapters were included.

An environmental scan was completed as a first step to creating a comprehensive strategy to address lactation in Indiana. Past progress was highlighted; partnerships and stakeholders were identified, as well as strengths and weaknesses needed to implement the CDC Guide to Strategies to Support Breastfeeding Mothers and Babies.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Pursue licensure for lactation consultants so that consultations can be reimbursed through insurance				X



2. Create and maintain a registry of statewide breastfeeding resources			X	
3. Continue to build and develop local breastfeeding coalitions throughout the state, with a focus on minority populations.		X		
4. Assist with Baby-Friendly Hospital implementation for interested hospitals.				X
5. Convene a task force to perform an environmental scan as a component of developing a comprehensive strategy to address the full spectrum of clinical and community-based lactation support.				X
6. ISDH and IPN host the annual invitation-only hospital summit for administrators of all birthing hospitals in the state September 2014.				X
7. ISDH will support birthing hospitals by providing model templates and assistance for implementing best practices for breastfeeding initiation				X
8. MCH will continue to convene an inter-agency task force that aligns breastfeeding initiatives taking place in all divisions.				X
9.				
10.				

#### **b. Current Activities**

ISDH will work with the National Institute for Children's Health Quality (NICHQ) and other internal and external partners to develop a comprehensive Indiana State Breastfeeding Plan.

IBC's clinical team along with ISDH Maternal Health Administrator will continue efforts to encourage hospitals to implement and follow evidence-based lactation practices, including encouraging disuse of complimentary discharge bags that include infant formula to all new families.

IPN will work in conjunction with ISBC to maintain and expand the online statewide directory of breastfeeding support services and the degree to which they are available in all 92 counties.

ISDH and IPN will continue to work with hospitals who wish to become Baby-Friendly and/or improve their mPINC scores.

ISDH will continue to collaborate with insurance companies and OMPP to streamline breast pump reimbursement and lactation counseling reimbursement.

ISDH is partnering with the EMPOWER Indiana and the Indiana Black Breastfeeding Coalition in an effort to educate African-American women in Marion and Allen counties about the link between optimal breastfeeding and obesity reduction for mothers and children throughout the lifespan.

#### **c. Plan for the Coming Year**

Specific action steps will be implemented after the strategic plan is finalized.

Planned activities include creating an initiative that induces hospitals to implement portions of Baby-Friendly practices to increase initiation rates.

Step up efforts to discourage use of infant formula discharge bags.

Create awareness of current exclusive breastfeeding rates at hospital discharge in accordance with the new perinatal core measures from the Joint Commission in order to improve compliance and implementation of best-practices.

Increase breastfeeding knowledge among doctors by evaluating curriculum and suggesting increased use of the AAP's Breastfeeding Residency Curriculum.

Continue efforts with managed care entities and private insurers to create and/or streamline reimbursement for professional lactation support and pumps and supplies as required. Support breastfeeding in the workplace initiatives in an effort to get more women to consider initiation of breastfeeding. Survey and assess interest for a Bring Your Baby to Work Program at ISDH as a first step towards piloting this program.

### **State Performance Measure 3:** *Percentage of pregnant women on Medicaid who smoke.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective			29.5	28.7	28.7
Annual Indicator	28.9	27.8	28.8	27	27
Numerator	11342	10850			
Denominator	39270	39071			
Data Source	ISDH - ERC	ISDH - ERC	ISDH-ERC	ISDH-ERC	ISDH-ERC
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	28.6	28.6	28.5	28.5	28.5

#### **Notes - 2013**

2013 Data based on trend analysis.  
ISDH-ERC

#### **Notes - 2012**

2012 Data is provisional.  
ISDH-ERC

#### **Notes - 2011**

2011 Data is based on a trend analysis

#### **a. Last Year's Accomplishments**

MCH continued to be an active member of the Promoting Smoke Free Pregnancy leadership team.

Members of the PSPI developed an action plan that will move the coalition in a new direction. Activities will education of residents and other providers, letters to legislators on prenatal smoking rates and need for non-smoking laws, conducting focus groups and interviews with prenatal care providers on prenatal smoking screening and intervention, and development of an effective message and communication strategy.

Provided training and materials to prenatal Medicaid providers through each Managed Care Entity to achieve at or above the 76th percentile the number of members who are advised to quit.

Conducted ongoing assessment of prenatal smoking data using monthly NOP data; vital records, Title V funded project quarterly reports, by county, race, Medicaid versus Non-Medicaid.

Created and disseminated prenatal smoking data briefs based on age, race/ethnicity, insurer, and geographical location of the targeted population.

MCH and Indiana Perinatal Network used data briefs to educate health care providers, local health department staff, community policy leaders, and consumers about the prevalence of smoking during pregnancy, including the consequences of smoking before, during and after pregnancy, best practice models for awareness activities to target low income women, and proposed best practice models to decrease smoking among women of childbearing age across the lifespan.

The Indiana Perinatal Network conducted key informant interviews on the topic of provider attitudes surrounding tobacco use during pregnancy.

All MCH Title V funded projects are mandated to ask all pregnant women if they smoke and then assist smokers to quit. Ongoing trainings with trainings with Title V funded projects and Prenatal Substance Use Prevention Programs (PSUPP) continued.

MCH continued to work with the Tobacco Prevention and Cessation division to get messages out to pregnant women on the dangers of smoking while pregnant. Other state and local MCH programs have been encouraged to include prenatal smoking messages with their program messages to reach a broader audience.

Implemented the Baby & Me Tobacco Free Program in 8 sites in Indiana in order to assist pregnant women stop smoking.

Updated State website with pertinent prenatal smoking information including facts, figures and resources.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Members of the PSPI training subcommittee will continue to provide regional trainings throughout the year for health care providers working with pregnant women.		X		
2. Implement new cessation programs (BMTF) for pregnant women throughout Indiana	X			
3. Conduct ongoing assessment of prenatal smoking data using monthly NOP data; vital records, Title V funded project quarterly reports, by county, race, Medicaid versus Non-Medicaid.			X	
4. Create and disseminate prenatal smoking data briefs to prenatal care provider, local health departments, and community policy leaders.			X	
5. Create and disseminate best practice models to decrease smoking among women of childbearing age across the lifespan.				X
6. Initiate a quality improvement project for community clinics to study contingency management in prenatal smoking cessation.				X
7. Updated State website with pertinent prenatal smoking information including facts, figures and resources.				X
8.				
9.				
10.				

**b. Current Activities**

Continue to explore best practices for treating smoking as a co-morbidity adverse health behavior with mental health problems.

Working with Promoting Smoke Free Pregnancy to provide training to prenatal care providers on assessment of mental health problems in all patients that smoke.

Encouraging Medicaid to add mental health assessment for high risk pregnant women who continue smoke during pregnancy.

Continuing to be a member of the Promoting Smoke-Free Pregnancies in Indiana Coalition. Provide data analysis, policy recommendations, and assist with provider trainings.

Continuing to increase smoking cessation among pregnant women on Medicaid as a member of the OMPP Neonatal Quality Committee. Monitor MCE performance metrics on smoking cessation and provide technical assistance and consultation on program improvements.

Monitoring vital record data for number of pregnant smokers who quit before delivery. Continuing the Baby & Me Tobacco Free Program in 8 funded sites throughout Indiana to address tobacco use during pregnancy.

Collaborating with Tobacco Prevention and Cessation to discuss options for best practices programs for future cessation services.

Continue to work with Indiana University School's of Public Health in Bloomington and Indianapolis to assess the threshold of contingency management as an inducement to aid in smoking cessation for pregnant women.

### **c. Plan for the Coming Year**

MCH continues its partnership with the Indiana University Schools of Public Health in both Bloomington and Indianapolis. This partnership will involve clinics in three Indiana counties, use biochemical means to get accurate quit rates and employ contingency management techniques to aid in cessation efforts.

MCH will expand the Baby & Me Tobacco Free Program to allow the baby's father to participate in this evidence-based contingency management program as a pilot to address the common barrier of lack of family support during the quit attempt. The target of this program will continue to be Medicaid eligible families in Indiana. Of special focus, is the quit rate for women and their families during their pregnancy, but also after delivery.

MCH will continue to sit on the Promoting Smoke Free Pregnancy leadership team. The team is focusing on providing workshops and technical assistance to communities throughout Indiana whose goal is to lower their prenatal smoking rates.

Indiana Perinatal Network will continue to be instrumental in delivering provider education during their statewide training series.

Continue to encourage providers to screen for tobacco use.

Prenatal Smoking Cessation has been adopted by the Perinatal Quality Improvement group's Education Committee as a high impact focus to reduce maternal and infant morbidity and mortality.

MCH will continue to engage in conversation with the Office of Medicaid Policy and Planning and Managed Care Entities to expand BMTF in Indiana and improve awareness of this program in

communities throughout Indiana.

Title V funded partners continue to screen for tobacco use during visits.

**State Performance Measure 4:** *The percent of black women (15 through 44) with a live birth whose prenatal visits were adequate.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	59	55	55	56.5	57
Annual Indicator	55.7	56.3	56.5	31.5	31.5
Numerator	5668	5631			
Denominator	10168	10006			
Data Source	ISDH - ERC	ISDH - ERC	ISDH-ERC	ISDH-ERC	ISDH-ERC
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	57.5	57.5	58	57	57

**Notes - 2013**

2013 Data is based on trend analysis.

ISDH-ERC

**Notes - 2012**

2012 Data is provisional.

ISDH-ERC

**Notes - 2011**

2011 Data is based on a trend analysis.

**a. Last Year's Accomplishments**

MCH had a booth at Black Expo in July 2013 to outreach to pregnant women and new moms and infants with messages about how to have a healthy baby, why immunizations are important, preconception information, information on Children with Special Health Needs Services, WIC, etc.

The life course continues to be discussed with ISDH Office of Minority Health (OMH) staff and how it affects the life of Blacks from birth to death. MCH continues to encourage integration of life course into all activities around black disparity were discussed and MCH encouraged perinatal health be included with diabetes and hypertension initiatives as impacting women before and during pregnancy can decrease chronic diseases in their offspring in later life.

Beginning January 1, 2013, the Indiana Family Social Services Administration (FSSA) will offer a new Medicaid program, Family Planning Eligibility Program, allowing men and women the ability to receive certain family planning services. The Family Planning Eligibility Program provides services and supplies to men and women for the primary purpose of preventing or delaying pregnancy. All women on pregnancy Medicaid will be transitioned to family planning services after 60 days postpartum.

Entrance into prenatal in the first trimester for Black women has improved 9.1% since 2008 (52.6%) to 2012 (57.4%) (2012 provisional data). However, there remains a disparity of 1.2 in

first trimester prenatal care between Black (57.4) and White (70.7) pregnant women according to provisional 2012 Natality data.

Local Minority Health Coalitions are continuing to promote Text4babies in their minority neighborhoods.

The Indiana Perinatal Network published 17P information for perinatal providers to encourage use among high risk women that qualify.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH will work with Medicaid and WIC to impact early preterm births and high postneonatal deaths among black infants.				X
2. Increase public awareness of black infant mortality, prematurity, increased postneonatal deaths, through media messages.		X		
3. Develop protocols and provider education around the use of 17P for black women who have had a previous live premature birth to prevent another premature birth.		X		
4. Encourage centering groups for black pregnant women at high risk for preterm birth				X
5. Continue to promote Text4baby				X
6. Participate in the fifth birthing hospital summit September, 2014				X
7.				
8.				
9.				
10.				

#### **b. Current Activities**

Work with Medicaid to impact early access to prenatal care and preterm births through policy changes and data assessment. OMPP continues pay for performance contracting with Medicaid Managed Care Entities for early entrance into prenatal care, and decreased preterm deliveries.

The fifth birthing hospital summit is scheduled for September 5, 2014. Attendance is by invitation for only of two to three executive/managers from each of the delivering hospitals, and representatives from MCH, IPN, Indiana Hospital Association, OMPP, and March of Dimes. New policies and procedures, and updated data on the status of pregnant women and infants in Indiana will be shared.

As part of the state infant mortality initiative, a FOA was released for local projects to impact infant mortality.

MCH is funding three Early Start clinics in Black perinatal disparity counties. Early Start clinics provide free pregnancy tests to county residences and initiates prenatal care at the time of a positive pregnancy test. A complete history and current risking occurs, as well as initial prenatal labs, exam, education, support, and enrollment into presumptive eligibility, pregnancy Medicaid, WIC, and other needed services. All women continue to receive prenatal care services through Early Start until they can get into care with a prenatal physician.

Lake County MCH clinic began providing centering for black pregnant women through the Gary Health Department with an infant mortality grant.

### c. Plan for the Coming Year

The Indiana Medicaid Health Coverage Programs (IHCP) now includes two authorized processes by which individuals can be determined presumptively eligible and receive temporary prenatal coverage until official eligibility is determined by the Family and Social Services Administration (FSSA). The Presumptive Eligibility for Pregnant Women (PEPW) process is a continuation of the current PE for pregnant women where women can enroll into managed care through prenatal clinics, community health centers, family planning clinics, and local health departments. The new Hospital Presumptive Eligibility (HPE) is a new process that began in January of 2014. The Hospital Presumptive Eligibility (HPE) process allows acute care hospitals to make presumptive eligibility determinations for women who are found to be pregnant in the emergency room or through hospital admittance for another reason. Reimbursement for this PE program will be fee-for-service.

Promote Presumptive Eligibility at the local level by collaborating with local minority health coalitions, neighborhood baby showers, faith based organizations, WIC.

Work with local Black Minority Health Coalitions to Implement the Free Pregnancy Test Program in counties where Black pregnant women have a lower entrance into early prenatal care than the state rate.

Encourage formation of centering pregnancy or support groups for high risk black pregnant women.

Explore use of peer educators (CHWs) in high risk communities to decrease disparity issues.

**State Performance Measure 5:** *The percentage of children less than 72 months of age with blood lead levels (BLL) equal to or greater than 10 micrograms per deciliter.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	0.7	0.6	0.6	1	0.9
Annual Indicator	0.9	1.1	1.0	1.1	1.0
Numerator		777	740	554	422
Denominator		69830	71125	51950	41022
Data Source	ISDH - Lead	ISDH - Lead	ISDH - Lead	ISDH - Lead	ISDH - Lead
Is the Data Provisional or Final?				Final	Final
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	0.8	0.7	0.6	0.6	0.6

#### Notes - 2013

2013 data is final.

ISDH-LEAD

#### Notes - 2012

2012 data is final.

ISDH-LEAD

## Notes - 2011

Data is based on trend analysis.

### a. Last Year's Accomplishments

ISDH's Indiana Lead and Healthy Homes Program (ILHHP) decreased the number of children with elevated blood lead levels by increasing primary prevention activities including increasing the overall number of environmental inspections and investigations.

ILHHP assisted communities with existing lead remediation grants by providing expertise and technical assistance when it was needed.

ILHHP improved training and increased the number of licensed lead professionals.

ILHHP increased enforcement of existing abatement regulations, as well as increased monitoring of abatement work activities.

ILHHP increased the number of Medicaid-eligible children that were screened.

ILHHP improved data collection and analysis.

ILHHP improved case management of lead-poisoned children by continuing the systematic training of local health department staff; overseeing radon professional licensing and staffing Radon Hotline; and expanding the program mission to include an overall healthy homes approach.

ILHHP attended several health fairs and outreach events to increase education and awareness of lead poisoning in a primary prevention focus.

ILHHP sent letters to primary care physicians and Managed Care Organizations as a reminder of their responsibilities to screen all children for lead poisoning.

Sunny Start released an addendum to the 2011 State of the Young Hoosier Child data report. The 2012 Sunny Start State of the Young Hoosier Child Environmental Health Report delves into the impact the environment has on young Hoosiers. It includes chapters on indicators of children's environmental health; the air children breathe; the water children drink, bathe, and play in; healthy housing and neighborhoods (including lead hazards); and healthy child care.

The MCH ECCS initiative (Sunny Start: Healthy Bodies, Healthy Minds) created new Fact Sheets on environmental impact information to families via the Early Childhood Meeting Place website. The sheets have been translated into Spanish. "Hits" to the website are tracked on Google Analytics.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ILHHP conducts training on the revised administrative rule 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING.				X
2. ILHHP works to improve case management of lead poisoned children by continuing the systematic training of local health department staff in the requirements of 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING.				X
3. ILHHP works to improve monitoring of the local responsibilities		X		



under the case management rule including environmental follow-up on lead poisoned children.				
4. ILHHP continues efforts to affect an increase in the percent of Medicaid screened children by encouraging Medicaid reimbursement for testing, case management, and environmental inspection.			X	
5. ILHHP improves data collections and comparisons with other programs such as Medicaid and WIC, use of the I-LEAD web application to produce consistent and effective risk assessments and environmental follow-up.				X
6. ILHHP increases awareness and outreach efforts including monitoring and disseminating product alerts from the Consumer Product Safety Commission bulletins and other sources of information regarding consumer product safety issues.		X		
7.				
8.				
9.				
10.				

#### **b. Current Activities**

ILHHP began implementation of a holistically oriented strategic plan. Activities include:

The assessment of existing healthy housing partners and identification of potential new partners that focus housing-related health issues;

The identification of housing-related health data variables to be collected & the development of data cleaning & dissemination plans;

The identification of an assessment tool to collect data & to document housing-related health hazards;

Assessment of housing conditions in high-risk areas;

Identification of at-risk populations for health issues related to housing;

Development of a TA/training process to address the needs of staff, coalitions & partners involved with healthy homes programming;

Development of risk communication/health education that supports housing-based prevention strategies targeted to high-risk areas/populations;

The addition of an Environmental Epidemiologist tassist with collecting/reporting data on Environmental Public Health;

Case Coordinators providing case management training to local health department staff with the absence of a Lead Health Educator;

Identification of barriers frequently associated with the case coordination process & development of a protocol to assure that appropriate follow-care is provided;

Assessment of current regulatory authorities relating to healthy homes;

Meeting with the appropriate officials to discuss effectively using existing authorities for addressing healthy homes issues;

**c. Plan for the Coming Year**

Work will continue by the MCH Division Lead Case Management staff and the Environmental Public Health Division staff to include:

Data collection as to the impact of lowering the case management level from 10ug/dL to 5ug/dL to be in line with the CDC reference level.

An application for the next available HUD Lead Hazard Control Grant, to continue to provide lead safe housing to Indiana's citizens.

The assessment of existing healthy housing partners and identification of potential new partners that focus housing-related health issues;

The identification of housing-related health data variables to be collected and the development of data cleaning and dissemination plans;

The identification of an assessment tool to collect data and to document housing-related health hazards;

Assessment of housing conditions in high-risk areas;

Identification of at-risk populations for health issues related to housing;

Development of a technical assistance/training process to address the needs of staff, coalitions and partners involved with healthy homes programming;

Development of risk communication/health education activities that support housing-based primary prevention strategies targeted to high-risk areas and populations;

Identification of barriers frequently associated with the case coordination process and development of a protocol to assure that appropriate follow-care is provided;

Assessment of current regulatory authorities relating to healthy homes;

Continued licensing of lead professionals in Indiana, as well as continued monitoring and enforcement of lead abatement projects within the state;

Continued licensing of radon professionals; staffing Radon Hotline; training environmental investigation staff to oversee radon mitigation activity; and

Continued participation by MCH staff on the Improving Kids' Environment Lead and Healthy Homes Task Force (a children's environmental advocacy group).

**State Performance Measure 6:** *The percentage of births that occur within 18 months of a previous birth to the same birth mother.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	15	14	36.1	35	34.9
Annual Indicator	35.4	34.4	35	33	33

Numerator	17768	16892			
Denominator	50188	49065			
Data Source	ISDH - ERC	ISDH - ERC	ISDH- ERC	ISDH-ERC	ISDH-ERC
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	34.8	34.7	34.6	34.7	34.7

#### **Notes - 2013**

2013 Data based on trend analysis

ISDH-ERC

#### **Notes - 2012**

2012 Data is provisional.

ISDH-ERC

#### **Notes - 2011**

2011 Data is based on trend analysis

Changes are because the data now represents Indiana residents, not edited for birthweight or gestation, and not restricted to singleton births.

Source of data: ISDH ERC

#### **a. Last Year's Accomplishments**

The Indiana Family Health Council (IFHC) continued to receive and administer Federal Title X funds from the U.S. Department of Health and Human Services (HHS) and the Indiana State Department of Health (ISDH) MCH Division for family planning services. IFHC also receives state assistance and funding for STI and HIV testing across the state, and partners with private foundations to provide reproductive health education and services.

As a Title V grantee IFHC's 10 state clinics are expected to provide preconception assessment, counseling and education. The IFHC developed a life plan tool that is used with all teens.

On January 1, 2013, Medicaid began offering a new Medicaid Family Planning Program for men and women at 133% of the federal poverty level. Covered services include annual exams, oral contraception, including emergency contraception; devices and supplies; diagnosis and treatment for STD/STI, tubal ligation and vasectomies. Part of the annual exam is to include preconception education and counseling.

According to the National Vital Records Final Report on Births for 2012, Indiana's teenage birth rate was 33.0, a 5% decrease from 34.8 in 2011. The average teen birth rate for Region V was 29.2, with Indiana having the highest rate of all Region V states.

The Indiana Perinatal Network lost staff, shifted its focus to breastfeeding, and did not reapply for MCH funding to work on family planning and preconception.

The Director of the ISDH Office of Women's Health was vacant for a time and the MCH Women's Health Program Administrator's title changed to Maternal Health focusing on breastfeeding, so the activities around preconception and interconception were put on hold.

#### **Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop a new Indiana Perinatal Quality Improvement Collaborative committee to address preconception and Interconception.				X
2. Work with ISDH grantees and division partners to integrate reproductive health messages into existing state health promotion programs.				X
3. Conduct training updates on preconception best practice models and new family planning methods with Title V funded projects.		X		
4. MCH infant mortality educator will work with established systems of community health workers or other community members to provide education regarding preconception health, interconception health, and breastfeeding support within their neighborhood				X
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

Promotion of interconception care is part of the Infant Mortality State Plan. The Indiana Perinatal Quality Improvement Collaborative (IPQIC) formed a new subcommittee to address interconception care.

IPQIC, System Interconception Care Subcommittee Deliverables:

Identify promising/best practices for providing Interconception Care for Women; Develop recommendations by March 31, 2015 for Best Practices for Interconception Care in Indiana that will support family medicine physicians, internists and obstetrician gynecologists in their work of providing high quality interconception care. The report should include recommendations for: Family involvement; Medical home model; Use of local community resources; A consultative model between women's health experts and primary care providers; and Ongoing collaboration with Perinatal Coordinated Centers of Care

The new MCH infant mortality educator will work with established systems of community health workers or other community members to provide education regarding preconception health, interconception health, and breastfeeding support within their neighborhood.

Share information about preconception services, Medicaid family planning, and birth spacing with Community Health Centers and WIC. Share with Title V grantees at 8/2014 meeting.

Evaluate and restructure the current MCH free pregnancy test program.

#### **c. Plan for the Coming Year**

Collaborate with the Indiana Minority Health Coalition to provide awareness initiatives around the Family Planning Eligibility Program in the 27 counties with local minority health coalitions.

Implement the revised free pregnancy test program in high risk counties.

Implement interconception follow-up of low and very low birthweight infants and their mothers into

new neonatal follow-up guidelines.

Implement the preconception adolescent health plan.

### **State Performance Measure 7: *Percentage of preterm births***

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective			13	11.8	11.7
Annual Indicator	11.8	11.7	11.8	10.7	10.7
Numerator	10192	9820		8878	
Denominator	86126	83867		83246	
Data Source	ISDH - ERC	ISDH - ERC	ISDH-ERC	ISDH-ERC	ISDH-ERC
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	11.7	11.6	11.6	11.6	11.6

#### **Notes - 2013**

2013 data is based on trend analysis.

ISDH-ERC

#### **Notes - 2012**

2012 Data is provisional

ISDH-ERC

#### **Notes - 2011**

2011 Data is based on a trend analysis.

ISDH-ERC

#### **a. Last Year's Accomplishments**

11-28-2012 first meeting of the Indiana Perinatal Quality Improvement Council was held at ISDH. The finalized Perinatal Hospital Levels of Care Standards were presented to the council for their review. The Quality Improvement Committee elected to recommend content for a hard stop policy to finalize efforts and ensure the content of policies and procedures in place across the state.

On 2-27-2013 our new State Health Commissioner Dr. VanNess announced infant mortality was a state priority. The Governing Council approved the Level of Care Standards.

MCH has a new business agreement with the Office of Vital Records to have direct access to birth and infant death certificates. MCH now has its own Epidemiology section with five epidemiologists.

The fourth perinatal hospital summit occurred 9-6-2013. The focus was on the gap analysis and IPQIC progress, with a breakout session on breastfeeding. 98% of all birthing hospitals attended.

MCH continues to collaborate with IN March of Dimes, IN Medicaid and the Indiana Hospital Association (IHA) on strategies to address prematurity. IN Medicaid promoted "40 Weeks of Pregnancy....Every Week Counts" through the three Medicaid Managed Care Entities (MCEs).

"40 Weeks of Pregnancy....Every Week Counts" provider toolkit and introductory letter to providers were sent out by each Managed Care Entity. Health plan representatives distributed and reviewed the toolkit content and resources with provider offices from mid-March to the first of June. Each MCE representative conducted a 3 month phone call evaluation on use of toolkit, knowledge gained, how patients accepted the patient material. The MCEs included a statement in their provider bulletin that "The Office of Medicaid Policy and Planning suggests that all risk-based, managed-care providers in Indiana maintain a C-section rate of 27 percent or lower." The Board of Directors of the Indiana Hospital Association (IHA) directed staff to provide resources on developing and implementing an early elective delivery hard stop to its members in collaboration with the March of Dimes, the Indiana Perinatal Network, the Indiana State Department of Health, the Indiana State Medical Association and the Office of Medicaid Policy and Planning.

The Quality Improvement Committee of the Indiana Perinatal Quality Improvement Collaborative (IPQIC) developed policy and procedures to support efforts in Indiana to reduce early elective deliveries prior to 39 weeks. The committee was made up of hospital administrators, directors of perinatal units, physicians, IN Medicaid, IN March of Dimes, and the IN Hospital Association, and March of Dimes. They will be presented to the IPQIC Governing Council in FY 2014 for approval. Review of Infant mortality by hospital and age at death revealed a 28.6% increase in infants dying <1 hr after birth (76 in 2010 vs. 97 in 2011). Further review will occur. Incidence of inductions and cesareans at 34-38 wks is reported quarterly through the Indiana State Health Improvement Project. The rate for first quarter of 2013 was 34.6%.

The Maternal and Child Health epidemiology team developed data reports of prematurity, very low birthweight, low birthweight, occurrence of induced vaginal deliveries and cesareans by each perinatal hospital, and incidence of infant mortality by cause in each region. ISDH Health Commissioner, Dr. VanNess, III, visited all hospitals in each region with MCH epidemiologists and the President of the IHA. Hospitals were pleased to get the data and information on infant mortality.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH will continue to work with Indiana Medicaid, Indiana Hospital Association, and March of Dimes to impact preterm births.				X
2. Increase public awareness of prematurity and what can be done to prevent it.		X		
3. Encourage physicians to use 17P for premature birth prevention in women who have had a previous live preterm delivery.			X	
4. Monitor and report maternal and infant birth indicators by hospitals			X	
5. Continue to provide facilitation, technical assistance and consultation to all IPQIC committees.				X
6. Conduct an in-depth analysis of inductions, cesareans, prematurity and neonatal deaths.			X	
7. Encourage centering groups for women at high risk for preterm births				X
8. Identify incidence of NAS in Indiana and the burden on premature birth rates.			X	
9. Develop hospital policy on identification and treatment of NAS in Indiana perinatal hospitals				X

### **b. Current Activities**

1/29/14, IHA and the Indiana State Department of Health (ISDH) announced that the rate of early elective deliveries before 39 weeks has been reduced from 11 percent in 2012 to less than 3 percent. Through quality improvement initiatives, hospitals across the state have been successful in reducing early elective deliveries. To date, 86 out of 92 delivering hospitals in Indiana have adopted hard-stop policies for all elective deliveries that do not meet medical criteria or receive approval from medical staff leadership. The Indiana Hospital Association, in conjunction with the ISDH Perinatal Quality Improvement Collaborative, developed a recommend hard-stop policy, scheduling form, consent form and data collection form on all early elective deliveries. IN Medicaid, as a member of the IPQIC will implement a no pay policy for inductions or cesareans prior to 39 wks on 7/1/14.

5/2014 another birthing hospital closed its birthing unit. An updated GIS spider map is being made showing where pregnant women in the 29 counties without a birthing unit travel for delivery, and how many delivered preterm and/or LBW.

The meeting of hospitals interested in being Perinatal Centers will be held on July 18, 2014. The fifth Indiana Perinatal Hospital Summit will occur 9/5/14.

MCH is funding an additional 7 prenatal care coordination (PNCC) programs throughout the state with Infant Mortality funds to decrease prematurity and low birthweight in their counties.

### **c. Plan for the Coming Year**

The second Indiana State Department of Health Infant Mortality Summit will be held November 13, 2014.

MCH will continue to work with Medicaid, Indiana Hospital Association, and March of Dimes to impact preterm births. All three agencies sit on The Indiana Perinatal Quality Improvement Collaborative as a member of the Governing Council, and as chairs of committees. The March of Dimes is chair of the provider and consumer education committee and will increase public awareness of prematurity and 17 hydroxyprogesterone (17P).

Physicians have been given a toolkit on 17P at a previous Hospital Summit but it is not known how many are using the toolkit. Medicaid reports they have had very few physicians bill for 17P. MCH epidemiologists will work with Medicaid and the Managed Care Entities to identify the current use of 17P injections and where use is occurring or not occurring. The IPQIC Quality Improvement sub-Committee will develop standardized policies and procedures for determining eligibility and use of 17P in collaboration with ISDH, IHA, and IN Medicaid that will be released to individual prenatal care providers and group providers.

Continue to contract with Emerald Consulting to provide facilitation, technical assistance and consultation to the IPQIC Governing Council and all committees. Provide current perinatal data by hospital and region to support the work of the committees.

MCH prenatal substance use program is funding projects in FY15 to continue to implement the Baby And Me--Tobacco Free/Quit For Baby Initiative to decrease Indiana's high prenatal smoking rates.

Continue to work with the ISDH Division of Vital Records to improve data collection on birth and death certificates to provide better quality data for analysis of perinatal outcomes. Indiana is seeing an increase in Neonatal Abstinence Syndrome (NAS). The Indiana Legislature instructed ISDH to develop a Neonatal Abstinence Syndrome (NAS) task force to define NAS and identify the population, and report the first two deliverables prescribed in SEA 408 by November 1, 2014. The task force has become an off shoot of IPQIC. The next deliverables will be to

develop standardized policies and procedures to assist hospitals in the identification and treatment of infants with NAS, and develop a training program for hospital neonatal staff. MCH epidemiology team will identify the current incidence of NAS and the relationship to prematurity rates. Conduct an in-depth analysis of inductions, cesareans, prematurity and increased neonatal deaths, with a special emphasis on early preterm births and early neonatal deaths. Maternal health issues such as obesity and diabetes will be analyzed for impact of prematurity rates.

**State Performance Measure 8:** *The percentage of women 18 to 44 who are overweight/obese.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			61	52	52
Annual Indicator	60.9	52.1	54.6	51.5	56.9
Numerator	3294	2819	560746	539320	
Denominator	5408	5410	1027008	1047224	
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Is the Data Provisional or Final?				Final	Final
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	51	51	51	51	51

**Notes - 2013**

2013 Data is final

BRFSS

**Notes - 2012**

2012 Data is final

**Notes - 2011**

2011 data is final

**a. Last Year's Accomplishments**

MCH worked with DNPA and the Indiana Healthy Weight Initiative to promote achieving and maintaining a healthy BMI in women of childbearing age.

MCH is examined the link of pre/interconception health, including obesity to maternal and infant mortality.

MCH is charged the expert panel of the Indiana Perinatal Quality Improvement Collaborative (IPQIC) with development of best practice guidelines for all birthing hospitals for assessment and treatment of obese women presenting for labor and delivery, especially as it relates to transport standards for at-risk mothers, and ensuring delivery in the appropriate level of care hospital.

MCH collaborated with the IU Center of Women's Excellence to promote healthy weight among women of child bearing age.

MCH is provided trainings on intervention programs to Title V grantees, community health centers, local health departments and Medicaid Managed Care Entities on the importance of the full integration of well-women care into their practices.

MCH promoted the Office of Women's Health Show Your Love campaign which emphasizes the



importance of maintaining a healthy weight as an essential component of preconception health.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All Title V grantees for 2012 are expected to weigh every patient, identify patients overweight or obese and provide some type of intervention.	X			
2. Continue to collaborate with DNPA on the Healthy Weight Initiative as it applies to women of childbearing age.			X	
3. Work with the ISDH Office of Women's Health to promote healthy preconception weight.				X
4. Collaborate with the Indiana Family Health Council Title X director to assure all women of childbearing age attended family planning clinic receives weight assessment and education on healthy weight.				X
5. Continue development of best practice guidelines for all birthing hospitals for assessment and treatment of obese women presenting for labor and delivery.				X
6. Outreach to direct care providers to encourage the practice of Every Woman, Every Time to empower women to make healthy lifestyle choices in regards to their reproductive life plan.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

MCH continues to focus on the link of obesity in pregnancy to maternal and infant mortality, adding an interconception subcommittee to the Indiana Perinatal Quality Improvement Collaborative (IPQIC) Systems Development team.

MCH is participating in the Region V COIIN for preconception health/interconception care initiative.

MCH continues to partner with the IU Center of Women's Excellence to include ongoing promotion of healthy weight among women of child bearing age.

MCH is developing a comprehensive statewide strategic plan to address breastfeeding exclusivity and duration rates which have been shown to positively affect maternal obesity rates.

MCH continues to provide educational opportunities to Title V grantees, community health centers, local health departments and Medicaid Managed Care Entities yearly.

MCH focused on lupus education and awareness this year during National Women's Health Week as a component of a life course approach to coping with chronic stress and alleviating symptoms of lupus in order to for women to life full and active lives.

MCH funds a women's wellness initiative in Boone County which utilizes free gym memberships as a component of women's wellness care.

**c. Plan for the Coming Year**

MCH is initiating a needs assessment related to female migrant farm workers of childbearing age to examine overall health, with obesity being one key factor.

MCH continue to partner with the Division of Nutrition and Physical Activity to focus on women of childbearing age's wellness needs, especially as it relates to access to safe places to exercise.

MCH will seek to expand the promising practice in Boone County of partnering women's wellness care with access to a gym membership.

MCH will continue to work with and charge the Indiana Perinatal Quality Improvement Collaborative (IPQIC) with development of best practice guidelines for all birthing hospitals for assessment and treatment of obese women presenting for labor and delivery.

MCH will continue to work with the IU Center of Women's Excellence to include ongoing promotion of healthy weight among women of child bearing age.

MCH will continue to focus on increasing breastfeeding duration and exclusivity as a key component of an overall strategy to improve women's health in the interconception period.

**State Performance Measure 9:** *Percentage of high school students who become infected with STI.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			1	1	1
Annual Indicator	0.8	1.2	2.4	2.5	2.5
Numerator	3883	5710	11291	11588	
Denominator	460787	460000	475515	470000	
Data Source	ISDH - STD/HIV	ISDH - STD/HIV	ISDH- STD/HIV	ISDH- STD/HIV	ISDH- STD/HIV
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	0.9	0.9	0.8	0.8	0.8

**Notes - 2013**

2013 Data is based on trend analysis

ISDH-STD/HIV

**Notes - 2012**

2012 Nominator is final.

Denominator is provisional and based on a trend analysis using 2010 census.

Source: ISDH STD Morbidity Report

**Notes - 2011**

2011 Numerator is final  
Denominator is from 2012 census data

**a. Last Year's Accomplishments**

SAHC served as the consultant for family planning services in Indiana. ISDH is partnering with the IFHC and its delegate agencies to promote screening for chlamydia and gonorrhea among adolescents.

MCH and the HIV/STD Division provided accurate, timely data on the prevalence of chlamydia, gonorrhea, and other STIs to grantees and community members and via reports on the ISDH web site.

MCH partnered with HCET to promote the text messaging campaign aimed at adolescents to encourage screenings for STIs and positive sexual health behaviors.

SAHC contracted with the Center of Excellence in Women's Health at Indiana University to send a Wellness on Wheels (WOW) bus to rural Indiana and provide free pregnancy tests, STI screening, and counseling about sex and abstinence.

MCH partnered with the HIV/STD Division to support any outreach or educational activities that reach the adolescent population.

SAHC supervised the YRBS Coordinator to disseminate data findings from the 2011 survey as well as assisted with the administration of the 2013 YRBS survey.

SAHC supervised the Abstinence Education Program Coordinator and their grantees, whose work to provide evidence-based abstinence education with the purpose of delaying early onset of sexual activity and preventing teen pregnancy, birth, and STIs.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ISDH continued to partner with IFHC and its delegate agencies to promote screening for Chlamydia and gonorrhea among adolescents.				X
2. MCH partnered with HCET to continue piloting and expanding on the texting program for parents to talk to their kids about STIs and sex.				X
3. SAHC continued to supervise the Abstinence Education program coordinators and their respective grantees, whose curriculum includes discussions on sexually transmitted infections.				X
4. SAHC continued supervising the YRBS Coordinator to disseminate data findings from the 2011 survey, which include information on STIs.				X
5. SAHC contracted with the Center of Excellence in Women's Health at Indiana University to send a Wellness on Wheels (WOW) bus to rural Indiana to provide free pregnancy tests, STI screening, and counseling about sex and abstinence.	X			
6. SAHC supervised the Abstinence Education Program Coordinator and their grantees, whose work to provide evidence-based abstinence education with the purpose of delaying early				X

onset of sexual activity and preventing teen pregnancy, birth, and STIs.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

SAHC is serving as the consultant for family planning services in Indiana. ISDH is partnering with the IFHC and its delegate agencies to promote screening for chlamydia and gonorrhea among adolescents.

MCH and the HIV/STD Division are providing accurate, timely data on the prevalence of chlamydia, gonorrhea, and other STIs to grantees and community members and via reports on the ISDH web site.

SAHC is supervising the YRBS Coordinator to disseminate data findings from the 2011 survey as well as assisting with the beginning stages of the administration for the 2015 YRBS survey. SAHC is also assisting with the administration of the 2014 School Health Profiles Survey which collects data regarding school health education, including issues of abstinence education and education on sexually transmitted infections.

SAHC is supervising the Abstinence Education Program Coordinator and his/her respective grantees. Evidence-based curriculum for abstinence education includes information on delaying early onset sexual activity and preventing transmission of sexually transmitted infections.

SAHC contracted with the Center of Excellence in Women's Health at Indiana University to send a Wellness on Wheels (WOW) bus to rural Indiana to provide free STI screening and counseling on sex.

SAHC contracted with Health Care Education and Training (HCET) to develop a texting method for parents to talk to their kids about STIs and sex.

#### **c. Plan for the Coming Year**

SAHC will continue to serve as the consultant for family planning services in Indiana. ISDH is partnering with the IFHC and its delegate agencies to promote screening for chlamydia and gonorrhea among adolescents.

SAHC will continue to supervise the Abstinence Education Program Coordinator and his/her grantees. Evidence-based curriculum for abstinence education includes information on delaying early onset sexual activity and preventing transmission of sexually transmitted infections.

SAHC will continue to supervise the YRBS Coordinator to disseminate data findings from the 2011 YRBS survey and the 2014 School Health Profiles Survey, as well as assist with the administration of the 2015 YRBS survey.

SAHC will contract with Health Care Education and Training (HCET) to continue developing and piloting the texting program for parents to talk to their kids about STIs and sex.

SAHC will contract with the Center of Excellence in Women's Health at Indiana University to send a Wellness on Wheels (WOW) bus to rural Indiana to provide free pregnancy tests, STI screening, and counseling about sex and abstinence.

**State Performance Measure 10:** *Build capacity for promoting social and emotional health in children from birth to age 5.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective			0.1	0.1	0.2
Annual Indicator		0.1	0.1	0.2	0.2
Numerator		5	10	14	21
Denominator		92	92	92	92
Data Source		ISDH/LHCS	ISDH/LHCS	ISDH/LHCS	ISDH-DMHA
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	0.3	0.3	0.4	0.4	0.4

**Notes - 2013**

2013 Data is provisional.

The Numerator is the number of counties on FSSA website that have endorsed or certified early childhood mental health providers for families.

The denominator is the total number of counties in the state.

**Notes - 2012**

2012 Data is provisional.

The Numerator is the number of counties that have endorsed or certified early childhood mental health providers for families. The denominator is the total number of counties in the state.

**Notes - 2011**

Data is final.

The Numerator is the number of counties that have endorsed or certified early childhood mental health providers for families. The denominator is the total number of counties in the state.

This number was changed from 22 to 10 after receiving final data.

**a. Last Year's Accomplishments**

The MI-AIMH (Michigan Association for Infant and Toddler Mental Health) Endorsement, a set of competencies and a credentialing process in infant mental health, continued to be implemented. The Endorsement Exam was offered in 2012 for the 2nd time. The third & final cohort of 17 providers completed training in May 2013 with funding from the Division of Mental Health and Addiction. Several members of this and previous cohorts took the third Endorsement exam which was offered in September 2013.

Annual conference & continuing ed. opportunities are available to early childhood providers including Introduction to Infant Mental Health training to Healthy Families Workers at each Institute and several regions including Versailles, Ft. Wayne, & Indianapolis.

A critical component of the Endorsement system is "reflective supervision." There was an ongoing group in Indianapolis and 5 additional individuals receiving phone supervision through the DMHA support.

A "community of practice" presence at the Institute for Strengthening Families in spring 2013 with a workshop on Reflective Supervision was supported by Sunny Start (ECCS). Shelley Mayse, LCSW, IMHE-IV, Mgr. of Early Childhood Mental Health for The Family Conservancy in Kansas City presented a workshop "Promoting Reflective Capacity and Wonder: Awaken to your Creative Spirit." The 3 hour workshop was offered 2 times with 60 people attending.

Six IN communities were identified/ supported to host a local event or series of sessions to promote the value/utility of Endorsement. TA was provided to all sites.

The Indiana Association for Infant and Toddler Mental Health (IAITMH) Board members presented at the Zero to Three National Training Institute @ Leadership Activities in IN. Dr. Angela Tomlin presented at the League of Endorsed States annual meeting in 12/2012 on a panel discussing competence in reflective practices.

Indiana was awarded an ECCS grant under Strategy 1: Mitigation of Toxic Stress and Trauma in children from birth to age 3. Working with the Indiana University School of Medicine's Riley Child Developmental Center, a training model will be developed and include 1) direct, didactic instruction delivered online to maximize attendance; 2) regularly available group reflective supervision opportunities delivered online to maximize attendance; and 3) support and mentoring to attain a specific infant mental health credential (Endorsement) that identifies the holder as having competency as a specialist in infant mental health/social and emotional development and allows the holder to function as a resource in his or her home community.

Annual conference and continuing education opportunities were available to early childhood providers. The annual IAITMH Annual Conference held in August 2013 focused on Young Children and Loss.

Indiana was also awarded the SAMHSA Project LAUNCH grant. The grant's goal is to ensure that children (from birth through age 8) have social, emotional, behavioral, cognitive and physical wellness.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MI-AIMH Endorsement, a set of competencies and a credentialing process in infant mental health, was adopted in Indiana				X
2. Twenty five providers; including Healthy Families workers, child care providers and Early Head Start home visitors will earn Level I endorsement				X
3. Thirty additional providers; including Healthy Families workers, child care providers and Early Head Start home visitors will earn Level I endorsement				X
4. Twelve Infant Toddler Specialists will earn Level II endorsement				X
5. Twenty five additional providers; including First Steps providers and DCS workers will receive a Level II endorsement				X
6. Ten providers who are currently members of the IAITMH Infant Mental Health Task Force will earn Level III endorsement, increasing the workforce capacity to provide direct services to families with young children who need a mental health intervention.				X
7. Ten providers who are employed at Community Mental Health Centers will participate in an intensive infant and early childhood mental health training experience, resulting in eligibility for Level III endorsement and increasing the workforce capacity				X
8. Five to ten additional providers will earn Level IV endorsement making them available to provide reflective supervision to				X

providers seeking Level I-IV endorsements.				
9. A university-based early childhood mental health certificate program will grow a pool of providers with education, training, and supervision required to meet criteria for Levels III and IV.				X
10. Annual Conference and Continuing Education Opportunities				X

#### **b. Current Activities**

The IAITMH accepted Endorsement applications at Levels 1 - 4 with the third Exam held in late 2013. Six applicants took the exam at Levels 3 and 4; all passed. There are 8 portfolios in the review process spanning Levels 1 - 4. The application and portfolio process is now available online; there are 7 applicants using this new feature! Ten Level 3 and 4 endorsed providers have volunteered to help mentor applicants and serve as portfolio reviewers. The application and review process will now be completed online.

The spring and fall 2013 Strengthening Families Institute included workshops focused on infant mental health and information about the endorsement.

The IAITMH continues to partner with the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) project to support the Level 1 and Level 2 Endorsement process for Home Visitors.

Through Project LAUNCH, a group of providers participated in a 2 day review of the training outlines for the online learning modules under development.

The IAITMH updated its website to better accommodate the expanding services and programs, especially the IMH Endorsement.

Dr. Angela Tomlin (funded through the ECCS grant) delivered a session at Zero to Three's 2013 National Training Institute, Emerging Research on Reflective Supervision: Defining Its Essential Elements and Demonstrating Its Impact. The presentation included information about research in reflective practice and supervision.

#### **c. Plan for the Coming Year**

All of these varied activities emanated from the strategy regarding social emotional development to support healthy social-emotional development in all children. Indiana has chosen to use the Endorsement system to support its emphasis on awareness, training and capacity-building in early childhood mental health.

The Endorsement system provides a framework to support the Sunny Start (ECCS) long term outcomes by establishing an ongoing system that promotes understanding and access to supports and services for all infants and toddlers throughout Indiana that experience concerns with social emotional development.

Establishing the Endorsement in the IAITMH supports its continuation beyond various grant programs and provides opportunity to reach many communities as well as the varied providers who serve infants and toddlers.

The support from Sunny Start Core Partners in both the philosophy and implementation of the Endorsement along with its varied training and enrollment activities is evidence of the value of this approach in achieving the outcomes set forth by Sunny Start.

Efforts will continue to encourage Head Start, child care, home visitors, early intervention, and other providers to apply to obtain a Level 1 or 2 Endorsement. There continues to be great support of the Endorsement from various Sunny Start (ECCS) partners resulting in a commitment to market the opportunity to a wide variety of providers. Seventeen counties have endorsed early childhood professionals through June 2014 with many more coming through the pipeline next

year.

Financial support from several partners allows providers to access training as well as the Endorsement application and the IAITMH membership annual fee for the first year. The Endorsement Exam is scheduled to be offered next in September 2014.

The ECCS grant from MCHB addressing a national priority to mitigate toxic stress and trauma in infancy has been received and is under implementation. A series of one hour online training sessions are under development and will be made available to early childhood providers to support their completion of Level 1 and 2 IMH Endorsement. The project also brings together representatives from various state agencies to promote use of the endorsement. In addition, opportunities to access reflective supervision will be expanded through online mechanisms to support individuals pursuing Levels 2, 3 and 4 Endorsement. This project supports Indiana's goal that Hoosier children are safe, healthy and reach their full potential.

## E. Health Status Indicators

**Health Status Indicators 01A:** *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Indicator	8.3	8.0	8.1	7.9	7.9
Numerator	7169	6732	6800	6563	
Denominator	86126	83867	83750	83250	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

### Notes - 2013

2013 Data is based on trend analysis.

ISDH-ERC

### Notes - 2012

2012 Data is provisional.

Source: ISDH-ERC

### Notes - 2011

2011 Data is provisional

Source: ISDH-ERC

### Narrative:

Health Status Indicators 01A, 01B, 02A, and 02B support MCH's focus on efforts to improve factors that contribute to low birth weight babies. Preconception, prenatal, and interconception



care are embedded in multiple Indiana State Department of Health programs that serve women at-risk for developing a low birth weight infant.

The Indiana State Department of Health has been working collaboratively with state and local agencies to address factors that impact low birth weights and infant mortality. ISDH plans to expand prenatal care coordination services throughout the state and promote initiatives to address infant mortality rates in Indiana. MCH currently funds 13 prenatal care coordination sites which provide prenatal care visits, health education classes, and breastfeeding education programs for mothers across the state. MCH programs also refer women to smoking cessation programs within the Indiana State Department of Health MCH Division.

In 2014, Maternal and Child Health, in partnership with the Division of Mental Health and Addiction will be implementing a state wide direct service program aimed to reduce the number of women smoking during pregnancy. The Quit for Baby grantees will be administering the Baby and Me--Tobacco Free™ program which is an evidence-based practice widely recognized for its quit rate. The Quit for Baby program is replacing the Prenatal Substance Use Prevention Program (PSUPP) which concentrated on alcohol, tobacco and other drugs. Because tobacco is a significant factor in poor birth outcomes, and Indiana has a high prenatal smoking rate, focusing on tobacco use during pregnancy has the potential to have a great impact on the health of women and families. ISDH will contract with 8 sites around the state in both rural and highly populated counties to reach a diverse group of clients.

In 2014, Maternal and Child Health will also be embarking on a project with the two school of public health at IU Bloomington and IUPUI in Indianapolis. This project seeks to determine the efficacy of using contingency management during smoking cessation education at various clinics in Indiana. Preliminary research suggests that using contingency management increases the likelihood that women will quit smoking during pregnancy, and stay quit after delivery. Working with Indiana University, ISDH will get critical information and data to help determine the future of helping women quit tobacco during pregnancy. This work will not only inform future programming, but has the potential to impact partners across the state and country.

In 2012, data indicates that the number of live births weighing less than 2,500 grams was 7.9 %. This data represents a slight decrease from 8.1% in 2011 but is consistent with data from 2010. Indiana had a higher percentage of low birth weight than the Health People 2020 Goal of 7.8 percent.

## **F. Other Program Activities**

In terms of maternal and child health, the effectiveness of our interventions and programs is an overriding issue. Many of our health status indicators and health outcome indicators over the past years have remained stagnant or gotten worse. While Indiana is not alone in this phenomenon, it is an issue we are addressing in a number of ways as discussed in the following paragraphs.

As discussed in Section III, State Overview, Indiana is near the bottom of all states in receipt of federal health dollars. Indiana ranks 48th for the amount of federal funding for public health from the CDC in FY 2009, 50th for Federal funding from HRSA, and 47th for the amount states provide for public health services. This lack of funding adversely impacts capacity. To combat these low funding levels, we will be examining all funded projects in the coming year to ensure their effectiveness. /2014/ Indiana ranks 50th for the amount of federal funding for public health from the CDC, 49th for federal funding from HRSA, and 36th for the state public health budget funding per capita during FY 2012. //2014//

Additionally, we are aggressively seeking additional grants that will allow Indiana to supplement

Title V funding for maternal and child health programs. Examples of grants for which we are applying include:

Teen Outreach Program (TOP) -- The Indiana State Department of Health (ISDH), in partnership with the Indiana Department of Education (DOE), Health Care Education and Training, Inc. (HCET) and the Center for Sexual Health Promotion (CSHP) at Indiana University recently submitted an application to the newly created federal Office of Adolescent Health to implement the Teen Outreach Program (TOP), an evidence-based, youth development and community service focused program to prevent teen pregnancy. This program is proposed to be implemented in 19 counties state-wide that have the highest rates of births among teens ages 15-19. Two goals of TOP are to reduce pregnancy rates and increase high school graduation rates. /2012/Indiana was not awarded this grant.//2012//

Innovative Social Media -- The purpose of this grant is to improve birth outcomes through socially interactive educational media. The media will improve understanding of the consequences of behavioral and environmental life choices on pregnancy outcomes. Socially interactive media will provide engaging, challenging and educational experiences that will be able to be spread beyond the original participants through shared media access.

MCH is proposing to develop and implement The Social Immersive Media Project for Life-course Education (SIMPLE). SIMPLE is an innovative social marketing approach to increase public awareness of the importance of integrating the life-course perspective into preconception/interconception planning and care; to reduce adverse outcomes and improve reproductive health; and to increase public awareness of the importance of preparing couples for transitioning into their roles as new parents. /2012/Grant was awarded. Program has been implemented. See Title V capacity section for more details.//2012// /2014/ MCH received a no cost extension for SIMPLE, when it was cut from a three year grant to a two year grant in 2012. MCH has decided to purchase a new, more portable interactive tool to house somewhere permanently- specifically in a hospital or clinic lobby. . The purchase was intended to occur by June 2013, however the contract was not set up in time to purchase. //2014//

ACA Maternal, Infant and Early Childhood Home Visiting Program Application -- Research indicates that healthy human development is connected to preventing poor outcomes that occur during the youngest years of a child's life. Early health indicators, including birth weight, immunization rates, and parental knowledge of proper child development, all are significant predictors of school performance and social engagement in later years. Problems apparent at this young age have been accurate predictors of IQ, educational attainment, criminal behavior, and even the probability of becoming a teenage mother. Programs that focus on comprehensive family-based programs have yielded strong outcomes for children, especially when they begin as early as possible. Home visitation programs that train new parents to be the "first teachers" of their young children have been very successful, especially if these programs work with parents over a period of several years.

In keeping with the partnership between HRSA and ACF, Indiana's Governor, the Honorable "Mitch" Daniels, has also recognized that the goal of an effective, comprehensive early childhood system is broader than the scope of any one agency. He has designated The Indiana State Department of Health (ISDH), through the Maternal and Child Health (MCH) Title V Division, and the Indiana Department of Child Services (DCS) as co-lead agencies for the State of Indiana's application for the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. Indiana will use this funding for two programs. Specifically, Indiana proposes to expand Healthy Families services within the already existing statewide network of Healthy Families providers, and to pilot the Nurse-Family Partnership home visiting services through a public-private partnership between ISDH/MCH and Goodwill Industries of Central Indiana. /2012/Updated State Plan was completed as well as one formula grant and one competitive grant.//2012// /2013/Competitive funding in the amount of \$9 million was awarded to Indiana.//2013//. /2014/ The current project end date is September 2016 with the last award for both the competitive and formula grants released to states in October 2015. To date, there have

been 1,669 home visits completed by Nurse Family Partnership on the formula grant and 1,643 home visits completed on the competitive grant. To date, there have been 3,226 home visits completed by Healthy Families Indiana on the formula grant and 10,068 home visits completed on the competitive grant. //2014// ***//2015/ As of March 31, 2014 there have been 3,798 home visits completed by Nurse Family Partnership on the formula grant and 7,208 home visits completed on the competitive grant. As of March 31, 2014, there have been 10,774 home visits completed by Healthy Families Indiana on the formula grant and 39,591 home visits completed on the competitive grant. //2015//***

We are also defining and implementing an evidence-based, life course health perspective that supports the knowledge that health is more than the absence of disease. As MCH moves in this direction, we are addressing a life course approach at the organizational level; developing and testing programs that incorporate a life course perspective; promoting pilot projects to test models that can be adopted and adapted in other locales; and sharing strategies and outcomes with non-traditional partners such as Goodwill Industries to further enhance knowledge, theory and practice.//2012/See Title V capacity section for how this program is developing.//2012//

//2012/MCH was awarded the Pregnant and Parenting Teen grant. The award amount is \$2 million a year for three years. With this award, MCH is providing four large subawards for direct services to pregnant and parenting teens 15 to 19 years old and funding research to identify effective ways to deliver health messages. MCH also completing a needs assessment to identify high risk communities. In August 2011, MCH will be seeking additional input from the community through a facilitated process.//2012// //2014/ Indiana submitted a competitive grant application in April 2013 to the Office of Adolescent Health for funding for the Pregnant and Parenting Adolescent Support Services (PPASS) Program at a total of \$1.5 million per year for the next four years to continue providing support to pregnant and parenting teens. Indiana did not receive the next round of PPASS funding for 2014-2017. //2014//

//2013/MCH has applied for a Project LAUNCH grant and has entered into a contract with the IU Division of Pediatrics to develop the first regional center, Circles of Indiana, to help people get out of poverty. MCH has also applied for an Abstinence Education Grant.//2013// //2014/ Indiana was awarded the Project Launch grant in September 2012, which provides \$834,716 per year for the next 5 years to develop the necessary infrastructure and system integration to ensure that Indiana children can thrive in safe, supportive environments and are entering school ready to learn and able to succeed. The project will target children ages 0--8 from low-income and minority families who participate in Goodwill programs. Indiana was awarded the Title V Abstinence Education Grant Program in September 2012, which provides \$1.047 million through September 30, 2013 and \$1.063 million through September 30, 2014. This money has established the Indiana Abstinence Education Program, which enables us to disperse funds to two community organizations, Social Health Association and The PEERS Project. //2014/ ***//2015/ In September 2013, our local implementation partner for Project LAUNCH discontinued their involvement with the grant. A new, competitive RFP was released that fall and awarded to Family Connections in Ripley County. They began implementing Project LAUNCH within their southeastern Indiana region in January 2014. The Indiana Ab Ed Program currently has three grantees: Social Health Association, The PEERS Project, and Boys and Girls Clubs of Indiana. A competitive RFP was released in April 2014 to fund our current grantees as well as any new organizations. //2015//***

## **G. Technical Assistance**

### **National Fatherhood Initiative**

Indiana State Department of Health (ISDH) is requesting technical assistance for Best Practices training for new fathers on the basics of child health and safety. This will teach fathers how to take care of their children during the pregnancy and after they are born. Early involvement of males in the pregnancy has positive benefits well beyond the birth of the child. For example, trainings engaging new dads and fathers in addressing the babies needs while in the womb and

after delivery have shown to assist mothers in receiving early, continuous, and adequate prenatal care. This can be due to the fact that the mothers have a support system from the start.

Unmarried mothers, or mothers where the fathers are absent from the home, are less likely to obtain prenatal care and more likely to have a low birth-weight baby. Researchers find that these negative effects persist even when they take into account factors such as education, which often distinguish a single parent from two-parent families. Expectant fathers can play a powerful role as advocates for prenatal care. Research has shown that 2/3rds of women whose partners attended a breastfeeding promotion class initiated breastfeeding. When the father or other family male(s) were involved, the mother received more prenatal care once enrolled.

ISDH is requesting technical assistance regarding the National Fatherhood Initiative (NFI). NFI offers Best Practices curriculums that actively involve fathers in the child's health care from conception and throughout childhood. Their curriculums include a variety of tools and resources for supporting fathers in many diverse settings. For example, they offer military programming, school-based programming, correctional programming, and Christian-based programming. For our purposes, we are interested in their health care programming which includes but is not limited to "Doctor Dad", "When Duct Tape Won't Work", and "Daddy Pack" (Exclusively for New Dads).

#### Bright Futures

ISDH is requesting training on the usage of the Bright Futures developmental tools for families and providers to address social and emotional health in children 0 through 5. This training should address each child's uniqueness due to the fact that all children face social and emotional challenges in early childhood, including learning how to control their emotions and tantrums and learning how to share, take turns, and play with others. With the use of Bright Futures tools, providers and families can begin a conversation together about how best to support healthy social and emotional development in infants, children, and teens. The tools encourage families who have any questions or concerns about their child's development to "check it out" and offer a number of tips for when, where, and how to seek assistance from local, state, or national resources.

Customized training, consultation, and technical assistance are available from Bright Futures at Georgetown University and the National Technical Assistance Center for Children's Mental Health. Through these organizations, ISDH would be able to utilize these tools in a variety of settings and for multiple purposes.

#### Capacity building for coalitions

ISDH is requesting technical assistance for infrastructure building and capacity building for coalitions. The Indiana Coalition to Improve Adolescent Health (ICIAH) was formed in late 2006. In May 2009, ICIAH released the state's first adolescent health plan. The focus of ICIAH is on the implementation of this plan with and through its partner organizations. However, ICIAH is struggling to get buy-in and commitment from its partners to take greater ownership in the implementation of the plan and promotion of ICIAH's work.

#### Cultural Competency Training

General issue-cultural competency training for MCH and its partners would be beneficial because Maternal and Child Health (MCH) faces diversity and health disparities among the population it serves. ISDH did provide annual training opportunities and refresher courses on cultural competency; however, such opportunities are no longer available. It is important for MCH staff and those we partner with and fund to have skills in this area in order to provide the best services for its clients. This type of training is available through MCHB and the National Center for Cultural Competency./2012/ MCH would like to focus on this training in FY12.//

## V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>1. Federal Allocation</b> (Line1, Form 2)	11662428	11606560	11899131		12245079	
<b>2. Unobligated Balance</b> (Line2, Form 2)	910310	910310	0		0	
<b>3. State Funds</b> (Line3, Form 2)	15795389	11756539	14477085		13825616	
<b>4. Local MCH Funds</b> (Line4, Form 2)	889823	282582	185347		281514	
<b>5. Other Funds</b> (Line5, Form 2)	2312108	1218656	991706		1208063	
<b>6. Program Income</b> (Line6, Form 2)	2795620	1546634	808249		812660	
<b>7. Subtotal</b>	34365678	27321281	28361518		28372932	
<b>8. Other Federal Funds</b> (Line10, Form 2)	9061151	7277382	15817537		15796793	
<b>9. Total</b> (Line11, Form 2)	43426829	34598663	44179055		44169725	

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Federal-State MCH Block Grant Partnership</b>						
<b>a. Pregnant Women</b>	5601748	4599142	3503035		4332291	
<b>b. Infants &lt; 1 year old</b>	2423081	2148271	3660589		3226874	
<b>c. Children 1 to 22 years old</b>	8393237	3998756	4762295		4093922	
<b>d. Children with</b>	17215212	13262529	14644661		14672493	

<b>Special Healthcare Needs</b>						
<b>e. Others</b>	0	2148124	1043672		939052	
<b>f. Administration</b>	732400	1164459	747266		1108300	
<b>g. SUBTOTAL</b>	34365678	27321281	28361518		28372932	
<b>II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).</b>						
<b>a. SPRANS</b>	0		0		0	
<b>b. SSDI</b>	65357		0		100000	
<b>c. CISS</b>	0		0		139805	
<b>d. Abstinence Education</b>	1047703		1009059		956462	
<b>e. Healthy Start</b>	150000		0		0	
<b>f. EMSC</b>	0		0		0	
<b>g. WIC</b>	0		0		0	
<b>h. AIDS</b>	0		0		0	
<b>i. CDC</b>	155650		65000		220560	
<b>j. Education</b>	0		0		0	
<b>k. Home Visiting</b>	4592841		11363717		10900264	
<b>k. Other</b>						
<b>Project LAUNCH</b>			834716		834716	
<b>PSUPP</b>			400600		400600	
<b>TANF</b>			1634891		1634891	
<b>Title XX</b>			369554		369699	
<b>UNHS</b>	249000				239796	
<b>ECCS</b>			140000			
<b>INSTEP/HD</b>	400000					
<b>PPASS</b>	2000000					
<b>PSUP</b>	400600					

#### Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Direct Health Care Services</b>	16729029	14672908	13040854		16614100	
<b>II. Enabling Services</b>	5247328	5982916	4811102		5319910	
<b>III. Population-Based Services</b>	5208239	5010038	4256394		3867082	
<b>IV. Infrastructure Building Services</b>	7181082	1655419	6253168		2571840	
<b>V. Federal-State Title V Block Grant Partnership Total</b>	34365678	27321281	28361518		28372932	

#### A. Expenditures

Indiana State agencies were required to hold a 3% reserve on all State funds in FY 2013, which accounts for some of the decreases in expenditures from the budget. Indiana continues to implement cost cutting initiatives that include elimination of non-crucial State positions and to require that all new or replacement State positions be approved by the State Strategic Hiring Committee, regardless of funding source. This has greatly impacted the amount of funds that

were allowed to be expended in the state/federal Title V partnership. See Forms 3, Form 4 and Form 5.

#### Maintenance of State Effort

Indiana's Maintenance of State Effort is \$11,539,520.00. In FY 2013, the MCH expected award was \$11,662,428.00. The State support is comprised of state and local funds that CHCS is authorized to spend on behalf of children with special health care needs. It also includes money for the 30% match required of local projects.

## **B. Budget**

For FY 2015, Indiana has budgeted \$2,964,913 or 24.2% of its annual budget for services to pregnant women, mothers and infants up to age one. Indiana has budgeted \$3,733,895 or 30.5% of its annual budget for family-centered, community-based, coordinated care and the development of community-based systems of care for children with special health care needs and their families. Indiana has budgeted \$3,675,585 or 30.0% of its annual MCH budget to provide services to preventive and primary care services for child and adolescents. Indiana is also budgeting \$762,386 or 6.2% for services provided to those falling into the Others category. This will include women over the age of 22 who utilize the services believing they are pregnant but are not. Also included in this amount is \$1,108,300 or 9.1% for Administrative Costs. This is 100% of the total MCH grant award.

\$16,614,100.00 has been budgeted for Direct Medical Care Services which includes all community grants that provide direct services and projected medical claims for CSHCS.

\$5,319,910.00 has been budgeted for Enabling Services which include all community grants that provide enabling services, and all other CSHCS state funds not projected for direct medical care services.

\$3,867,082.00 has been budgeted for Population Based Services these services include all community grants that will provide population based services and Newborn Screening funds. This category has previously included Indiana RESPECT funds, but those funds are now being used to fulfill the match requirements of our Abstinence Education funding.

\$2,571,840.00 has been budgeted toward Infrastructure Building Services. These funds include our epidemiology and information technology staff. ISDH grantees are using more evidence-based approaches, meaning ISDH can spend fewer dollars on external evaluation and direct those funds toward Direct and Enabling services.

#### FY'15

##### Unobligated Funds

The State of Indiana still maintains the cost-savings measures that have been implemented in the last few years. Despite these measures, Indiana intends to fully utilize the funds granted to us for FY 2015. Indiana has a renewed focus on infant mortality rates and intends to create several new positions to focus solely on infant mortality. In FY 14 Indiana started a new grant program to focus specifically on infant mortality. Additional State funds will be put toward this priority as well.

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.